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:	Glencorry
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	27 April 2023
Centre ID:	OSV-0002383
Fieldwork ID:	MON-0039548

About the designated centre

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

Glencorry is a designated centre operated by St. Michael's House. It is located in a campus based service for persons with intellectual disabilities located in North Dublin. The centre comprises of one large building and provides full-time residential services to six persons with intellectual disabilities. The building consists of six resident bedrooms, a large living room, a large dining room, a kitchen and separate pantry space, a staff office, a staff room, a bathroom, a separate shower room, a utility room, and a large entrance hallway. There is an outdoor patio space to the front of the centre with an area for outdoor dining, a seating area, raised planting beds and a water feature. Residents are supported by a person in charge, a clinical nurse manager, staff nurses, social care workers, care workers, a cook, and a household worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 27 April 2023	09:00hrs to 17:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This inspection was an unannounced risk-based inspection carried out in response to an increased pattern of notifications relating to peer-to-peer safeguarding incidents, submitted to the Health Information and Quality Authority (HIQA).

The inspector was provided with the opportunity to meet with four of the five residents living in the centre. The inspector spoke with the person in charge, staff, and a number of residents. While some of the residents spoke with the inspector, not all residents provided their views on the service they were in receipt of. A review of documentation and observations, throughout the course of the inspection, were also used to inform a judgment on residents' experience of living in the centre.

On the day of the inspection, two residents were attending their day service, one resident was having a day off from their day-service, one resident had retired from their day service and one resident, due to ongoing ill-health, was not in attendance at a day service. This resident was currently being supported to attend a local venue on a one-one basis with a staff member, as part of a safeguarding plan but also, until they were able to return to a day-service that met their needs.

One of the residents told the inspector of the enjoyable time they had the previous day. The said that they were in Howth by the beach and had enjoyed a strawberry ice-cream. The also told the inspector that they enjoyed going to the local church and attending the mass service on Sundays. The resident was having a relaxing morning, having had a lie-in and late breakfast and had planned to head to the library in the afternoon.

Another residents told the inspector that they had a nice relaxing Jacuzzi bath that morning and had enjoyed a healthy breakfast afterwards. In the afternoon they had planned to go for a medical appointment. During the conversation, the inspector observed staff support the resident to go outside to the back garden to feed the cat. The inspector joined the staff and the resident in the garden. The resident appeared happy and was smiling when engaging with the cat. The inspector observed the resident to appear anxious when they engaged in conversation about the whereabouts of another resident. The inspector also observed, how staff were able to support the resident by redirecting the conversation in a mindful and caring manner.

One of the residents had chose to take a day off from their day service. For the most of the day, the inspector observed the resident to sit and listen to music. The person in charge told the inspector that the resident enjoyed to spend time in quiet areas of the house, and for some part of the day was sitting in the foyer area by themselves listening to their music.

In the afternoon, the inspector met one other resident when they returned from their day service. Before the resident had arrived home, a plan had been put in

place to avoid crossover between the resident arriving and another resident leaving. This was in line with a current safeguarding plan in place, due to incompatibility issues in the house between some residents.

At the time, the resident chose not to engage with the inspector and this was respected by the inspector who left the resident to continue their activity with staff. Later in the day, the inspector observed the resident have a family member call to the house for a visit. The resident appeared happy to see their family member and afterwards appeared to be in a good mood following on from the visit.

Overall, on speaking with residents, staff and the person in charge and on review of activities discussed at residents meetings, the inspector saw that, for the most part, residents were provided with an array of activities in their home and the community. There was an group music session planned for the residents that evening. Some of the residents sang a few lines from songs for the inspector when the session was mentioned. Residents also enjoy activities in the community such as going to the beauticians, hairdressers, going to local Cafés and restaurants, the supermarket and post office but to mention a few.

Due to the negative impact of compatibility issues in the house, there had been an arrangement implemented to support some residents to avoid interaction with each other as much as possible. This was to ensure their safety and the safety of other residents living in the house. However, the impact of keeping residents safe meant that their rights were not promoted at all times. Residents' right to independently move freely around their own home was limited at times. For example, in communal areas where residents gathered, staff members were required to supervise at all times.

For the most part, residents and where appropriate, their families, were consulted in the running of the centre. Residents participated in weekly residents' meetings where matters such as activities, menu plans, weekly shopping, organisational updates and complaints were discussed on a regular basis.

On review of the minutes of a residents meeting in October 2022, the inspector saw that residents were informed about a new resident moving into their home. From minutes of a November 2022 residents' meeting, after a new resident had moved in, the inspector saw that residents were asked how they were getting on with the new resident. The inspector found, that, while there was mention of a new resident, overall, there was limited detail in the minutes to demonstrate meaningful consultation with residents regarding a new person coming to live in their home.

Staff advised the inspector that in general, residents did not raise any complaints at the meetings however, post-meeting, staff would speak with residents on a one-to-one basis to follow up about any complaints residents may of had and not wish to air in a group situation. On review of the complaint's log the inspector saw that eleven complaints had been submitted on behalf of residents by their staff. The complaints related to the impact compatibility issues were having on their right to privacy and dignity and their right to safe and effective service. One resident also submitted a complaint about how the compatibility issues in their home was

impacting on their right to access and freedom of movement in their own home.

On walking around the designated centre, the inspector observed that the premises were clean, spacious and homely. Overall, the house was in good decorative upkeep and structural repair. Each resident had their own room; residents' bedrooms were laid out in a way that was personal to them and included items that was of interest to them. For example, bedrooms included family photographs, pictures and memorabilia, ornaments and soft furnishing and fittings that were in line with the residents' preferences and likes. There were two bathrooms available for residents use and included appropriate assistive aids that were required by residents. There was a large living area and separate dining area including a separate kitchen and pantry room. Outside the house there was a garden, that included a covered pergola. The inspector was informed that during good weather, residents enjoyed sitting outside in this area, as it provided good protection from the sun.

Residents were supported by a team of nurses and direct support workers and a part-time housekeeping staff. There were two nursing staff vacancies and a cook vacancy at the time of inspection. The inspector observed staff to provide support that was person-centred. Staff were kind, supportive and jovial in their interactions with residents and residents appeared relaxed and comfortable in the presence of staff.

In summary, through speaking with management and through observations and a review of documentation, it was evident that the management team and staff were striving to ensure that residents lived in a supportive and caring environment. However, due to on-going compatibility issues in the centre and the arrangements in place to keep residents safe, at times, the environment was restrictive in nature. In addition, not all residents were living as independently as they were capable of, in their own home.

This is discussed in the next two sections of the report which presents the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impact on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

In the months prior to the inspection, there had been an increase of solicited notifications relating to alleged safeguarding peer-to-peer incidents occurring between some residents in the designated centre. In addition, there had been an increase in non-serious injuries notified to the Health Information and Quality Authority between quarter three of 2022 and quarter four of 2022. A number of the non-serious injuries relating to self-injurious behaviours.

In response to this, HIQA issued the provider with a provider assurance report requesting information and assurances with regards to how the provider was

addressing the ongoing pattern of incidents in the centre. The provider submitted an assurance response and for the most part, satisfactory assurances were provided. However, despite an assurance provided the pattern of incidents continued and as a result this inspection was carried out to assess regulatory compliance in the centre and the impact of such incidents on the lived experience of residents and to review the provider's implementation of actions outlined on the provider assurance report response they had submitted.

As part of the inspection, the inspector noted that the recent change of needs for a resident living in the centre meant that the service provided was no longer meeting their assessed needs and was resulting in some of the peer-to-peer safeguarding incidents occurring in the centre. On the day of the inspection, the provider advised they were currently in the process of assembling a business case so that the resident could be provided with a service that better met their changing needs.

However, despite the strategies and efforts made in the preceding months, the ongoing compatibility issues continued to impact negatively on the lived experience of the residents. In addition, the support plans in place, that were endeavouring to keep residents safe, were at times, resulting in an environment that was restrictive in nature.

Overall, the inspector found, the provider had put in place a number of strategies to better ensure the safety of residents in their home, these were found to be having some impact. The provider had also engaged with external services regarding the continued compatibility issues in the house and had followed up with the appropriate allied health professionals and arranged multi-disciplinary team input to provide support to residents' concerned, but improvements were required.

There was a clearly defined management structure that identified the lines of authority and accountability and staff had specific roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by the provider, who was knowledgeable about the support needs of each resident. A clinical nurse manager, (CNMI), supported the person in charge with the centre's administration, operational management and oversight systems of the designed centre.

The provider had completed an annual report in April 2023 of the quality and safety of care and support in the designated centre during 2022 and there was a lot of evidence to demonstrate that residents and their families were consulted in a meaningful way about the review. The provider was also carrying out unannounced six-monthly reviews of the centre which included action plans and time-lines for the person in charge to follow up on.

There was a quality enhancement plan in place which was reviewed regularly and updated with required actions and the completion of the actions. There was a local auditing system in place, known as monthly data reports These reports formed part of the organisation's governance arrangements in the centre and were reviewed by senior management. On the day of the inspection, there was no record of these reports since January 2023 however, there was an action identified in the previously

submitted provider assurance report response to HIQA, to have the reports completed by the person in charge by June 2023.

The person in charge ensured that team meetings were taking place regularly. On review of a sample team meeting minutes, the inspector found that the meetings promoted shared learning and supported an environment where staff could raise concerns about the quality and safety of the care and support provided to residents. In particular, where behavioural incidents had occurred and where residents' plans were updated, the person in charge and staff engaged in reflective practice and shared learning.

In line with the submitted provider assurance response action plan, a review of minutes of meetings also demonstrated the person in charge had organised, on two separate occasions, for appropriate professionals to join the team meetings to inform, discuss and share learning regarding the on-going compatibility issues and changing needs of residents.

There was a planned and actual roster and it was maintained appropriately. The centre was staffed by a team of skilled senior and staff nurses, social care workers, direct support assistants and housekeeping staff. For the most part, staffing arrangements on a day by day basis included enough staff to meet the needs of residents however, overall the current staff compliment was not in line with the statement of purpose. There were two vacancies which are covered by relief and agency staff. Overall, on review of the roster for March and April 2023, the inspector found that that provider and person in charge had not ensured continuity of care at all times.

For the most part, staff were provided with appropriate training in fire safety, safeguarding, positive behaviour supports, infection, prevention and control and food hygiene, but to mention a few. Overall, staff training, including refresher training, was up-to-date however, improvements were needed to ensure that staff were provided training that was specific to the assessed needs of residents. Improvements were also needed to ensure that staff were provided with supervision meetings in line with the schedule in place.

The provider had developed and implemented an admission policy, including protocols, which were in line with the admission's criteria in the centre's statement of purpose. The protocols included a consultation phase of admission where a multi-disciplinary team (MDT) supports the person in charge to get to know the future resident and understand their support needs. A discussion between the person in charge and MDT team results in an outcome of suitability of the placement. If a place is to be offered, the person in charge ensures there is consultation with current residents.

The inspection found that this procedure had been, for the most part implemented was in place to ensure that the appropriate assessments take place to ensure the safety of the resident moving into the centre and the safety of residents already living in the centre. However, on review of records for the most recent admission of a resident to the centre, the inspector found, that, consultation with the residents

already living in the centre required improvement to ensure their voice and feedback was recorded and considered in a meaningful way.

Overall, there was effective information governance arrangements in place to ensure that the designated centre complied with notification requirements. The inspector found that the person in charge ensured that incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. However, some improvements were needed to the quarterly reports to ensure that they included all restrictive practices in the centre.

There was an complaints procedure in place that was in an accessible and set out in an accessible format, which included access to an advocate when making a complaint or raising a concern. The person in charge ensured that the complaints' procedures and protocols were evident and appropriately displayed and available to residents and families.

There was an easy-to-read information poster displayed in the front entrance area of the designated centre which included details of the complaint's officer. The complaint form was also in an easy-read format, with age appropriate pictures, and included a variety questions to guide and support residents relay as much information as possible about their complaint.

Regulation 15: Staffing

There were two staff vacancies; one senior staff nurse and one staff nurse. While, the provider was actively recruiting for these positions, vacancies were being covered by the organisation's relief staff and external agency staff.

The centre's roster for March 2023, demonstrated that, throughout the month, there were thirteen different agency staff employed to cover gaps. In addition, there was one day were a gap on the roster went uncovered.

However, in April 2023 the number of agency staff had reduced significantly and the planned roster for May 2023 had again shown a significant reduction in the use of different agency staff with one agency and relief staff included on the roster for the month.

Staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre.

Staff were continuously advocating on behalf of residents and supported them relayed concerns about compatibility issues through the complaints process.

Judgment: Compliant

Regulation 16: Training and staff development

There was a training matrix in place which identified training completed by staff and training due. On the day of the inspection, the person in charge updated the matrix in line with each staff member's current training. Overall, the majority of staff training was up-to-date, including refresher training.

Since the last inspection all staff had been provided with positive behavioural support training and on speaking with staff, this had been beneficial to their practice. In addition, the person in charge and provider had arranged for a designated officer and an allied professional member of the multi-disciplinary team to sit in on two staff meetings to discuss and share learning on matters relating to safeguarding, behavioural needs and supports.

However, the inspector found that improvements were needed to ensure that all staff were provided training in line with residents' assessed needs. For example, training relating to autism and mental health had not been made available to staff working in the centre.

Staff were provided with one-to-one supervision meetings four times a year. On speaking with staff they advised that they found these meetings to be beneficial to their practice. There was a supervision schedule in place for 2023. However, on review of supervision meetings completed for February 2023, the inspector saw that over half of the staff had not been provided with the planned February meeting.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider was endeavouring to reduce the number of safeguarding incidents occurring in the house and had put a number of strategies in place to ensure all residents' safety, however, improvements were required. Due to the changing needs of a resident, the provider could no longer ensure that the centre was meeting their assessed needs.

A disability support application management tool (DSMAT) had been completed by the person in charge and service manager which demonstrated that the resident's need would be better met in an individualised service. On the day of the inspection, the provider advised the inspector that they had met with their region's national safeguarding team and were currently collating assessments and recommendations on the needs of the resident (from the appropriate health care and MDT professionals) to attach to the business case they were preparing to submit. However, as of the day of the inspection, there was no time-line in place for the plan to be completed or submitted.

The person in charge was allotted a number of administration hours per week, to support them carry out the effective governance, operational management and administration of the designed centre.

Overall, the inspector found that a review of the time allocating to the person in charge for administration tasks was required to ensure that they were provided sufficient time to carry out their duties in a timely manner to ensure the smooth and effective deliver of the service. For example, not all staff supervision meetings were on schedule, monthly data reports had not commenced, not all restrictive practices had been submitted accurately and the training matrix was not updated until the day of inspection.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The inspector found that the recent admission of a resident to the designated centre was carried out in line with their assessed needs and was person centred in nature for them. However, improvements were needed to ensure that admission also considered a person-centred approach for residents already living in the centre.

Senior service management members, allied health professionals and members of MDT team consulted with the person in charge during two separate meetings as a way of ensuring the service could meet the potential resident's assessed needs. The minutes from the second consultation meeting referred to the established likes and dislikes of other residents living in the house (in relation to compatibility with the potential resident), and noted no compatibility issues had been identified. However, there was no detail of how this was determined. In addition, apart from a small note in the minutes of the residents' meeting in October 2022, there was no satisfactory documented evidence of meaningful consultation with residents living in the house about a new person coming to live in their home. Subsequent to the inspection, the person in charge submitted documented evidence of telephone calls made to family members to advise them that a new person was moving into their family member's home.

Furthermore, not all of the organisation’s admission's protocol, in particular, the approval stage of the protocol, was adequately followed. For example, the protocol, states that to support a new resident move in and to allow for current residents to get to know the resident in a slow and steady pace, a transition plan is developed which involves a number of short visits to the centre including visits for dinner, opportunities to stay overnight and stay for a weekend.

However, to better meet the needs and to provide a person-centred approach for the new resident, the provider arranged for them to move into the centre without any visits, overnight or weekend stays. This was not in line with what other residents in the house were used to and had the potential to be a difficult change

for them. In addition, the provider had not identified the potential risks of this situation in advance of the admission; there was no appropriate risk assessment completed to ensure all necessary controls were in place.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations. For the most part, the person in charge had also ensured that quarterly notifications were being submitted as set out in the regulations. Not all environmental restraints had been included on the forth quarterly notification for 2022 however this had been rectified by the next quarter.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was monitored for effectiveness, including outcomes for residents so that residents continued to received quality, safe and effective services. Since January 2023, eleven complaints had been submitted. On review of the complaint forms, the inspector saw that staff had advocated on behalf of a number of residents to make a complaint about the ongoing compatibility issues in their home.

The inspector found that where a complaint had been made, they had been dealt with in an appropriate and timely manner and included actions that had been put in place to reach an outcome. However, as all of the complaints related to compatibility issues, which were ongoing, the satisfaction of the outcome of the complainants had been noted as 'not satisfied'. The person in charge advised, that until the compatibility issues was mitigated, the residents' complaints would remain open.

Judgment: Compliant

Quality and safety

The person in charge and staff were endeavouring to ensure that residents' wellbeing and welfare was maintained to a good standard. It was evident that the person in charge and staff were aware of residents' needs and knowledgeable in the

person-centred care practices required to meet those needs. Care and support provided to residents was of good quality. However, due to a continuance of compatibility issues in the centre, the lived experience of residents was not always positive.

The inspector found that while a number of strategies had been implemented to reduce the risk of peer-to-peer safeguarding incidents occurring in the designated centre, compatibility issues remained. Where appropriate, residents were provided on-going support from appropriate multi-disciplinary team members. Initially the implementation of the strategies saw a decrease in safeguarding incidents for a short while but had increased again.

Many of the incidents were occurring in communal spaces in the centre and were impacting in a negative way for residents. In addition, the inspector found, that while the safeguarding strategies had for the most part, ensured residents safety, they had in turn impacted on the rights of residents. Safeguarding plans in place meant that on daily basis, residents' freedom of movement and independence in their own home, and in particular, communal areas of the house, was at times, restricted.

The inspector reviewed a sample of residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs and for most residents, arrangements were in place to meet those needs. This ensured that the supports put in place maximised each resident's personal development in accordance to their wishes, individual needs and choices. The plans were regularly reviewed and residents, and where appropriate their family members, were consulted in the planning and review process of their personal plans.

Where residents had recently moved to the centre, they had been provided with a robust transition plan. On review of the plan the inspector saw that it was person centred in nature and was provided in a format that the resident could understand. The resident and their family were consulted in the development, implementation and review of the plan in advance of the the resident moving to the centre. In addition, an assessment of the resident's needs, as part of their personal plan, had been carried out with the resident within the required regulatory time frame.

While residents were being supported to understand their right to make a complaint on a regular basis, to make choices through weekly residents' group meetings and with their keyworkers, overall the inspector found that the designated centre was not promoting the rights of residents at all times. The inspector found that the on-going compatibility issues in the house was impacting on residents rights in a negative way and in particular, in relation to their right to a safe and effective service.

Regulation 12: Personal possessions

During the last inspection, it was found that not all residents had ownership of their

own finances, and that support provided was not in line with residents' assessed needs and preferences. The provider advised in their July 2022 compliance plan that the person in charge and organisation's finance manager were in the process of final completion to set up alternative banking arrangements for a resident to facilitate the resident's financial accessibility and autonomy of all personal funds. However, while some actions had been completed, as of the day of the inspection this action had not been fully completed and a bank account had not yet been set up for the resident.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There were multidisciplinary reviews of residents assessed needs as well as the supports to meet their needs on regular basis and more often if needed. The reviews were effective and took into account changes in circumstances and new developments in residents' lives. Residents' personal plans reflected the revised assessed needs of residents and in particular, where a safeguarding incidents had occurred, where appropriate residents' personal plans were updated and additional supports put in place.

Where a resident's needs were identified as changing, the provider and person in charge had engaged with the appropriate healthcare and MDT professionals to put supports in place to meet their changing needs. These teams were part of the continuous consultation process in the development, implementation and review of safeguarding plans for all residents living in the centre. An additional space had been sourced in the community for the resident to spend some quiet one-to-one time with staff. Additional staff supervision in communal areas of the house was in place and on a daily basis, plans were in place for staggered meal-times, routines and crossover. Overall, while some of these supports were assisting the resident's assessed needs overall, they were not effective at all times and where this was the case, resulted in safeguarding incidents. As such, the centre was currently not meeting the assessed needs of all residents. This has been addressed in Regulation 8 and 9.

Judgment: Compliant

Regulation 8: Protection

On review of a sample of incident records, the inspector saw that staff were adhering to residents' safeguarding plans when de-escalating or pre-empting an incident. Some of the strategies within the plans included staggering and supervising morning routines, in particular, breakfast time. Strategies also included minimising

time residents spend together in shared communal spaces, limited cross over between residents and in particular, when a resident returned home from their day service or family visit. Staff were required to supervise residents in communal areas and when required, to move residents from one communal area of the house to another or to their room, (where staff envisaged a behavioural incident occurring). For the most part, these strategies were effective however, due to the needs of residents, staggering routines or planned cross-overs could not always be accommodated and where this was the case, a safeguarding incident occurred.

Through conversations with staff, and through a review of documentation, the inspector found that not all residents enjoyed who they were living with. Staff had supported a resident to make a complaint about how the compatibility issues was making them unhappy and overall, impacting on their rights as a resident in their home.

Overall, the inspector found, that while the current living arrangements were in place, residents continued to be impacted in a negative way. In addition, the risk of continued safeguarding incidents occurring in communal areas and during cross over times (of residents coming and going) in the house, remained. Furthermore, although strategies were more likely to keep residents safe, this resulted in a more restrictive living environment for residents and overall, impacted negatively on their lived experience in their own home.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector found that residents rights were not being promoted in the centre at all times.

There were eleven complaints submitted since January 2023. For the most part, the complaints related to residents' right to access and freedom of movement in their home, their right to privacy and dignity, their right to safe and effective services.

Safeguarding plans in place, while endeavouring to ensure residents' safety, resulted in an environment that was restrictive in nature. In addition, the plans meant that residents' independence in their own home was limited at times.

Due to compatibility issues in the house, residents' right to a peaceful, quiet and relaxing environment, was not being met at all times.

As the house was not meeting all resident's needs, this meant that not all residents' right to live in a house, that was suitable to their needs, were being met.

On walk around of the house, the inspector observed documentation regarding fluid in-take on the kitchen wall (which included information that was personal to the resident). In this case, the right to privacy and dignity in relation to personal

information was not being met.

Where there was a recent admission of a resident to the centre, overall, the records and documentation in place did not provide assurances that residents were supported to engage in the consultation process in a meaningful way. In this particular event, it was more important as the resident was moving in to the house without any advance, dinner, over-night or week-end visits.

Notwithstanding the above, staff advocated on behalf of residents on a regular basis and supported residents to submit complaints when they were unhappy or when their rights were being impacted. Residents' meetings took place on a weekly basis where residents were supported to make choices about their meals, activities and where issues were discussed and decisions made. Residents and where appropriate were consulted and participated in the annual review of the care and support provided in the centre in a meaningful way.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glencorry OSV-0002383

Inspection ID: MON-0039548

Date of inspection: 27/04/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training relating to autism has been scheduled for the staff team on the 23rd of June 2023 • Training relating to mental health supports has been requested from the MHID team and will be scheduled for the Autumn • All outstanding staff supervision has been rescheduled and protected time assigned on the roster to complete • PIC has requested roster review to address management time allocated to PIC for administration tasks including supervision of staff within the designated centre; in order to ensure effective governance, operational management and administration of the designated centre.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A disability support application management tool (DSMAT) had been completed by the person in charge and service manager seeking approval for further staffing supports to ensure that residents needs are met in line with their assessed needs and risk assessments. • The service manager and PIC are collating a business case to present to the HSE for funding for an individualised wrap around residential placement for one resident based on assessed needs and psychiatric assessment requested	

• PIC has requested roster review to address time allocated to PIC for administration to support them carry out the effective governance, operational management and administration of the designed centre.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • The Service Manager and PIC will review all future admissions and consider the risk assessing of the potential impact on service users residing in the centre for fast paced admissions due to residents individual assessed needs.	

Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • Director of Finance and SMH Housing Compliance and Tenancy Support Manager continue to engage with a Financial institution and the following are the next steps that the Provider is taking with the Vulnerable Customer unit. • An application form will be sent to Provider for completion from the financial institution • Once complete, the Provider will submit the form back to the financial institution along with the resident's identification and proof of address letter • The Financial institution Vulnerable customer unit will then arrange a visit with the residents as part of the application process • The Financial institution vulnerable customer unit will then arrange a meeting with the SMH Finance Manager, the PIC of the centre and the Care Facility Manager to call to the branch to verify details and signatories • Once all the necessary requirements are met, the account for the residents will be set up and they will receive a letter confirming their new account details	

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The registered provider has submitted a disability support application management tool (DSMAT) to the HSE requesting funding for additional staff to support one resident with complex mental health needs
• The service manager and PIC are collating a business case to present to the HSE for funding for an individualised wrap around residential placement for one resident based on assessed needs.
o The director of estates has identified a potential site within the service to accommodate a premises suitable to meet the assessed needs of resident.
o The director of estates will appoint an architect to design plans for suitable premises.
o Pending funding from the HSE the director of estates will commence tender process
• When resident is experiencing acute mental health deterioration, a 72 hour escalation is completed to provide additional staffing to support residents and maintain safety and wellbeing of all residents within the centre.
• All potential safeguarding incidents are screened by the principal social worker and a preliminary screening form submitted to the designated officer if required and NF06 submitted to HIQA
• There are on-going safeguarding meetings to discuss and review safeguarding plans with the PIC, Service Manager, Designated Officer, Director of Adult Services, Principal Social Worker and the HSE Safeguarding team. The Service Manager and PIC will ensure that any potential rights restrictions are discussed and reviewed as part of the next meeting.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• All staff members in Glencorry will complete online learning course The Fundamentals of Advocacy in health and social care (On HSeLand) in order to better support residents to have their will and preference met and have their voices heard.

• The PIC will be completing Strengthening rights training- for mentors as part of Strengthening Disabilities project in St. Michael's House on 15th June 2023.

• Service user's personal information removed from kitchen wall on day of inspection, all information is kept in a folder personal to the resident. This was highlighted to all team members and was discussed at staff meeting.

• Restrictive practices are reviewed regularly by PIC and new application is submitted to Positive Approaches Monitoring Group (PAMG) for approval annually.

• A review of restrictive practices with psychologist will be completed on a six monthly basis, to ensure ongoing formal review of restrictions and that least restrictive option is utilized in support of residents.

• The service manager and PIC are collating a business case to present to the HSE for funding for an individualised wrap around residential placement for one resident based on assessed needs.

• The PIC and staff team ensure that all residents have the opportunity to exercise their choice and control in their daily life through daily activity planning, day service attendance and weekly residents' meetings.

• There are on going safeguarding meeting to discuss and review safeguarding plans with the PIC, Service Manager, Designated Officer, Director of Adult Services, Principal Social Worker and the HSE Safeguarding team.

• The PIC has introduced rights support plans for residents to ensure that all staff are consistent in their support for residents in exercising their rights within the centre.

• All residents are consulted and participate in the organisation of the designated centre through weekly residents meetings, yearly annual reviews and through six monthly unannounced audits carried out by the Service Manager.

• A representative from the organisations Quality and Safety Team has provided support and training to the staff team to support with advocacy and promoting service users rights within the centre.

• All residents are supported to access external advocacy services as per their will and preference.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/12/2023
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	30/09/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/07/2023

Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/12/2023
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	30/09/2023
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/06/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/06/2024
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes,	Not Compliant	Orange	30/11/2023

	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(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	30/11/2023
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	31/12/2023