Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Glen 3
Name of provider:	Avista CLG
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	05 and 06 June 2024
Centre ID:	OSV-0003727
Fieldwork ID:	MON-0036234

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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	09:30hrs to 17:30hrs	Erin Clarke	Lead
Thursday 6 June 2024	10:00hrs to 16:20hrs	Erin Clarke	Lead
Wednesday 5 June 2024	09:30hrs to 17:30hrs	Carmel Glynn	Support

What residents told us and what inspectors observed

This announced 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. This included meeting senior management to discuss oversight and progress with quality improvement initiatives for the wider campus. Overall, the inspectors found high and improved levels of compliance with the regulations. Effective governance and oversight systems had identified and addressed issues in response to residents' needs.

The inspector also found that improvements had been made in several areas in this centre since the last inspection, which positively impacted the residents. However, as discussed in the report, further improvements were needed in staffing, staff training and development, and restrictive practices.

The designated centre is located on a congregated mixed-use campus setting with two other designated centres with an overall capacity of 52 residents. The centre comprises three separate bungalows located adjacent to each other and each bungalow was designated to accommodate certain support needs. In addition to the residential service, the campus also contained a school, an adult day service, a restaurant, and administration offices. Residents had access to individual bungalow gardens, as well as other communal gardens and a small prayer room. Residents' bedrooms in all houses were tastefully and individually decorated, with plentiful storage space for personal belongings.

The centre was registered to accommodate 16 adult residents, and there were no vacancies at the time of this inspection. One bungalow accommodated six residents, and the other two bungalows accommodated five residents each. The inspector had the opportunity to meet and spend time with all of the 16 residents who lived in the designated centre and to visit all three bungalows over the course of two days. The majority of residents had lived in their homes for many years, and in accordance with their assessed needs, they primarily required staff support with regard to positive behaviour support, sensory support, social care needs, healthcare and mobility needs. Other residents required support with their mental health and emotional wellbeing. A team of nursing staff, healthcare assistants, and clinical nurse managers supported the residents day and night.

The layout of each of the purpose-built bungalows was similar to that of the others; each contained a combined kitchen, dining room, and sitting room. Due to its limited size, the kitchen was not accessible to all residents. Meals for residents were prepared in a centralised kitchen within the campus restaurant. Meal options were discussed at residents' meetings, and meals were ordered a week in advance. The inspector observed the mealtime experience in one house. Hot meals were collected in a trolley and brought from the centralised kitchen. Appropriate arrangements

were in place to keep the food warm, with temperatures recorded accordingly. While meal options were ordered in advance by residents, residents could choose an alternative meal if their appetite or preferences had changed. One resident who did not wish to have a dinner-type meal at lunchtime had their meal prepared by staff in the house with the stock of food available.

During the course of the inspection over two days, the inspector met with all the residents. Residents had varied communication needs, including speech, specific phrases, gestures, and non-verbal cues. Some residents relied on staff to interpret their responses and communicate effectively. The inspector observed residents leading staff by the hand to indicate what they required or areas of interest. Detailed communication support plans observed by the inspector captured the unique styles of communication for residents, which supported staff in responding to and understanding residents' needs. Staff were observed to interact warmly with residents. The inspector saw that staff and residents' communications were familiar and kind. Staff were observed to be responsive to residents' requests and assisted residents in a respectful manner.

The inspector was informed that one resident was not feeling too well, and staff were monitoring for any changes in the resident while they rested watching television. The resident did not speak directly to the inspector but engaged with staff and the person in charge. The inspector observed the staff using clear communication as per the resident's support plan.

In one bungalow visited by the inspector, five residents participated in their morning routines with the support of staff. Residents were supported in having tea, taking medicines and getting ready to leave the centre for coffee later in the day. Pictures around the centre showed residents engaging in activities throughout the year such as attending a Christmas party, birthday parties and the zoo.

All staff spoken with demonstrated good awareness and knowledge of residents' healthcare and personal needs. One staff member spoke about their training in applying a human-rights based approach to health and social care. They understood and used the principles of Fairness, Respect, Equality, Dignity and Autonomy (FREDA) in their keyworking sessions with a resident to determine their preferences and likes.

One resident living in this house had a private living room in line with their assessed needs. The provider was reviewing the living environment for this resident to ensure it maintained a safe and suitable space for the resident and also reflected the resident's personal preferences for living alone. These longer-term plans were discussed with the inspector, and they involved annexing the resident's living space away from the main building. This resident had their own garden accessible via an accessible entrance, which had been enhanced with sensory features since the last inspection. Automatic bird sound sensors, scented plants and tactile items were placed around the garden for the resident's enjoyment.

Residents had access to day service programmes on campus, which they could choose to attend based on their own interests. These included reflexology, zumba

exercise classes and arts and crafts. Day service staff and the designated centre staff also supported residents in accessing activities in the community. Each bungalow had a vehicle so residents could safely leave the campus and attend activities and outings. The location of the centre did not lend itself to availing of public transport and pedestrian facilities, including lack of road crossings and wheelchair-friendly footpaths. Management informed the inspector that they had recently lobbied for improved community accessibility through local county council representatives who had visited the centre as part of local elections.

The inspector observed the planning of using the centre vehicles during the inspection, and it required staff to alternate vehicles between houses and enter the houses to discuss the plans for the residents. As not all staff could drive the vehicles, it was an activity that required advance notice and planning in some cases. It was also reported that there was some incompatibility between staff driving licenses and the transmission of the vehicles. The inspector was informed that the provision of vehicles was an area under consideration at a provider level.

The inspector found the centre's atmosphere to be warm and friendly, and residents appeared to be very happy with the support they received. At times, however, it was noted that the centre was busy, particularly noise-wise, due to the communication between different bungalows on the campus. While the designated centre operated separately from the other designated centres, the staff had processes and procedures to support and respond to calls for assistance in other bungalows. A bleep system was in operation, and staff carried audio receivers, which transitioned instructions from other staff. At various times throughout the inspection, updates were transmitted regarding fire drills and medical emergencies. One transition alerted staff to a fire call, and staff that were not supporting staff left the centre to support another bungalow and returned when it had become known it was a false alarm. Fire drills or tests carried out in one part of the campus were relayed to repeater panels located in the office of each bungalow. Two medical emergencies occurred in the centre over the two days, which were also communicated via the bleep system.

There was a high level of environmental restrictions implemented within the centre, for safety and risk purposes. The inspector found a good level of oversight and scrutiny of restriction practices overall and a reduction in some restrictive practices since the last inspection through the implementation of rights reduction plans. The inspector identified one restrictive practice during the inspection that was not referred to the restrictive practice committee for oversight and brought this to the attention of the person in charge.

Overall, the inspection found increased compliance with the regulations and improved monitoring systems in the centre to identify and address areas of concern. Residents were supported to have a comfortable and meaningful life, with an increased emphasis on supporting choice and preferences. The areas that required improvement, as outlined in this report, were mostly known to the provider and were part of the centre's quality improvement plan.

The next two sections of the report present the findings of this inspection in relation

to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing compliance with the regulations and contribute to the decision-making process for the renewal of the centre's registration. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service and how effective they were in ensuring that a good-quality and safe service was being provided.

This inspection found improved management systems in place to ensure that the service provided to residents in the centre was safe, consistent, and appropriate to their needs. There were various oversight strategies which were found to be effective both in relation to monitoring practices, and in quality improvement in various areas of care and support. In addition, the provider had addressed long-standing resource issues in the centre. For example, staffing levels had recently been stabilised which reduced the need for and use of large numbers of agency staff. Also while improvements had been made to addressing training requirements in the centre further work was required in this area.

The centre was last inspected in January 2024. While the inspection found that the centre's governance and management structures were improving in terms of monitoring, they were still not entirely effective. During the inspection, the centre still had numerous staffing vacancies, which has been an ongoing concern despite the provider's recruitment efforts. At the time of the inspection the registered provider had vacancies across all grades consisting of three nurses, four healthcare assistants and one social care worker, representing around a third of the required staffing levels. In their statement of purpose, the provider had committed to having ten WTE nurses, 15 healthcare workers and 2.5 social care workers employed in the centre to provide safe care.

During the inspection, the inspector was updated on the progress made in addressing the staffing deficits that had been noted during the previous inspection. The provider had recently held a recruitment fair and had successfully recruited two new staff nurses, three healthcare assistants and one social care worker who had commenced in the centre or were going through pre-employment checks.

The person in charge informed the inspector they were satisfied with the improved staffing arrangements and rosters, saying it was easier to book familiar relief and agency staff and schedule team meetings. Team meetings were now planned as part of the monthly planned roster, and all staff were required to attend either in person or online. The person in charge and clinical nurse managers provided informal support and formal supervision to staff in line with the provider's supervision and probation policies. Records of formal supervision and probation

reviews were maintained.

The management structure in the centre was clearly defined, with associated responsibilities and lines of authority. The person in charge was full-time, and found to be suitably skilled, experienced, and qualified for their role. They had responsibility for this centre alone. The person in charge demonstrated effective governance, operational management and administration of the centre. There were good oversight arrangements in place, which assisted in ensuring that the care provided was held to a good standard at all times. Oversight arrangements included the completion of mandatory audits and reviews as set out in the regulations, as well as internal audits, which were completed by both the person in charge and by designated staff members. It was clear that each person in the management structure and staff team understood their roles and responsibilities, which ensured that accountability was promoted in this centre.

The provider had implemented an effective complaints procedure for residents which was underpinned by a written policy. The policy outlined the relevant persons' roles and responsibilities, and arrangements for residents to access advocacy services. The procedure had been prepared in an easy-to-read format and was readily available in the centre for residents and their representatives to view. It had also been discussed with residents at a recent meeting to support their understanding of the procedure.

The registered provider had prepared a written statement of purpose that contained the information set out in Schedule 1. The statement of purpose clearly described the service and how it is delivered. As part of their governance for the centre, the registered provider had prepared and implemented written policies and procedures on the matters set out in Schedule 5.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted an application to renew the centre's registration. The application contained the required information set out under this regulation and the related schedules, such as floor plans, a statement of purpose, and the residents' guide.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge held a full-time position and was regularly present at the centre to meet with their staff team and the residents. They were supported in their role by their line manager and staff team. They had appropriate qualifications and professional experience of working and managing services for people with

disabilities. Current governance and management arrangements gave them the capacity to ensure this centre was effectively managed.

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 members during the day. At night, five staff members were on duty across the designated centre, and arrangements were in place for how staff supported each other and who to contact in the event of an emergency. There were some remaining vacancies in the complement, which the provider was recruiting for. The vacancies were filled by regular agency staff and permanent staff working additional hours to reduce any adverse impact on residents and support continuity of care.

Additional funding had been approved for one resident in the centre for an increase in staff support due to a change in needs. This resident was recommended to use a vehicle by themselves with additional staff to support access in the community.

The inspector found that while the skill mix of staff was sufficient and the provider had stabilised the staff team in the centre through extensive recruitment, there were, at times, not enough drivers scheduled. From speaking with staff, it appeared that the vehicles assigned to the centre were satisfactory in facilitating residents' outings but that the number of approved drivers and licenses had sometimes limited the use of the vehicles and therefore some trips required planning.

The person in charge maintained planned and actual staff rotas. The rotas clearly showed the staff on duty in the centre during the day and night. The inspector spoke to several staff members of different grades and found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

A review of staff files was completed during the inspection. They were found to contain the information and documents specified in schedule 2 of the regulations. The provider had valid contracts in place for staff members as well as a vetting disclosure in accordance with the National Vetting Bureau. There were no gaps noted in relation to the provider's records that were reviewed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors reviewed the staff training matrix for 28 staff and found that the

completion rate of staff training had improved since the last inspection. All staff had completed fire safety, manual handling, safeguarding food safety and human rights training. Two staff were booked for fire safety training, and two new staff were to complete training in managing behaviours of concern and safeguarding.

Training related to the use of fire evacuation aids and safe swallowing however had a significant number of outstanding staff. Fifty per cent of staff had not received training in fire evcuations aids or were due a refresher and similarly 35% of staff were overdue training in feeding, eating, drinking and swallowing difficulties (FEDS). Both of these areas were known risks for the centre due to residents' assessed needs.

Staff also attended team meetings which provided an opportunity for them to raise any concerns regarding the quality and safety of care provided to residents. The inspector viewed a sample of the recent staff team meeting minutes, which reflected discussions on complaints, safeguarding of residents, audit findings, hazards in the centre, fire safety, and the Assisted Decision-Making (Capacity) Act, 2015.

Supervision records reviewed were in line with organisation policy and the inspector found that staff were receiving regular formal and informal supervision as appropriate to their role. The person in charge had completed a schedule of supervision for the coming year. Staff could also utilise onsite night manager clinical or operational support if required.

Judgment: Substantially compliant

Regulation 21: Records

Obtaining required documentation had been identified as an area of non compliance on the last inspection. The inspector found that all of the required documents for this inspection were available and easy to access in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and their reporting relationships. The provider had also made tangible progress towards actions identified in the previous inspection of the centre.

The person in charge reported to a clinical nurse manager three, who in turn reported to the campus service manager. There were effective arrangements, such

as meetings, for the management team to communicate and escalate information.

Two night managers were recruited in October 2023 who held the post of clinical nurse managers grade two (CMN2). The night managers were based on site from 8pm to 8am to provide clinical support to staff and residents and perform auditing functions. A health promotion officer was employed on the campus to oversee and improve healthcare services for residents. This included tasks like immunisation, monitoring and overseeing healthcare conditions, and addressing infection prevention and control issues

There were quality assurance systems for maintaining oversight of the service such as the annual and six-monthly quality and safety reviews. The annual review provided for consultation with the resident and their representatives. A schedule of audits was in place, including audits of person-centered plans, health and safety arrangements, and medicine management. Any required actions identified in these audits were added to a quality improvement plan and monitored until complete. Actions from the previous inspection regarding the six-monthly audit of the centre had been addressed.

Judgment: Compliant

Regulation 3: Statement of purpose

A statement of purpose was in place for the designated centre. The statement of purpose was found to contain all of the information as required by Schedule 1 of the regulations. The statement of purpose had been recently reviewed and updated in April 2024 to reflect changes in the designated centres management and staffing ratio.

The statement of purpose outlined sufficiently the services and facilities provided in the designated centre, its staffing complement and the organisational structure of the centre and clearly outlined information pertaining to the residents' well-being and safety.

A copy of the statement of purpose was readily available to the inspectors on the day of inspection. It was also available to residents and their representatives.

Judgment: Compliant

Regulation 31: Notification of incidents

In advance of this inspection, the inspector reviewed notifications that had been submitted regarding this designated centre to the Chief Inspector. The person in charge had ensured that incidents, as detailed under this regulation, which had

occurred in the centre were notified to the Chief Inspector.

The inspector found that where incidents did occur, these were appropriately managed using a person-centred response and are reviewed as part of the provider's continuous quality improvement measure. This is with the objective of enabling effective learning and preventing a possible recurrence.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints process formed part of the continuous quality improvement checks within the centre. The quality and safety team had identified areas for improvement in the recording and closing of complaints, which had been actioned. The inspector found there was good oversight of complaints at a campus level to ensure areas for improvement were captured and incorporated into the annual review and formed the basis for quality enhancement plans.

Judgment: Compliant

Regulation 4: Written policies and procedures

There were relevant policies and procedures in place in the centre which were an important part of the governance and management systems to ensure safe and effective care was provided to residents, including guiding staff in delivering safe and appropriate care.

On a review of the centre's schedule 5 policies, all policies and procedures had been reviewed in line with the regulatory requirements.

Judgment: Compliant

Quality and safety

Overall, the inspector observed positive outcomes in the centre due to the improved and strengthened capacity and capabilities of the provider. In particular, the presence of familiar staff to residents had greatly improved. Also, residents' care plans demonstrated high-quality input that considered the unique requirements and abilities of residents. In line with previous inspections of the centre, one bungalow did not fully meet the needs of one resident who expressed a preference to live by

themselves. Plans were underway to address this long-standing wish of the resident.

As previously mentioned, there were a high number of restrictive practices in the centre for identified safety and wellbeing risks. These included nighttime checks, bed sponsor alarms, chair sensor mats, locked doors, modified clothing, bedrails and sound monitors. In total, 23 restrictive practices were notified to the chief inspector and were subject to review by the provider's restrictive practice oversight committee. While the inspector identified an additional restrictive practice in the application of a protective helmet, overall, it was found that restrictive practices were subject to regular scrutiny for effectiveness and appropriate use. Front doors to the three bungalows had all been removed from a swipe door system following a period of risk assessment.

The person in charge had ensured that residents' health, personal and social care needs had been assessed. The assessments informed the development of care plans for staff to follow. The inspector viewed a sample of residents' care plans, including those on positive behaviour support, communication, dietary needs, nutrition, mobility, safety, intimate care, and specific health conditions. The plans were up to date, readily available to guide staff practices, and noted residents' participation. The plans also reflected multidisciplinary team input as required. For example, speech and language therapy, occupational therapy, positive behaviour support, and other specialist health services.

Residents had good access to members of the multi-disciplinary team, including the occupational therapist and physiotherapist therapist. The residents had a general practitioner (GP) who attended the campus on a weekly schedule. There were also arrangements for residents to access GP services outside of these times. During the inspection, the inspector met with the health promotion officer, who supported the GP in their medical reviews of residents. They also coordinated healthcare screening programmes and infection prevention control initiatives and provided oversight to the clinical needs of residents.

The provider had taken measures to protect residents from abuse. Up-to-date safeguarding policies and procedures were available, and all staff had completed safeguarding training. Intimate care plans were available on resident files. These were written in person-centred language and provided clear steps for staff to support residents in a way that respected residents' dignity and autonomy and was mindful of individual preferences.

However, there remained a residual risk to residents' wellbeing due to some residents preferring to live by themselves or with fewer peers. The risk was reduced with the implementation of safeguarding plans and increased staffing levels. However, as progress towards de-congregation in line with national policy had not commenced, this matter required ongoing close monitoring by the provider to ensure that residents' preferences and wellbeing were upheld.

Regulation 11: Visits

Residents were supported and encouraged to maintain connections with their friends and families. There were no restrictions on visiting the centre, and there was plenty of space to meet with visitors privately if they wished. Some residents received regular visits from family members, and some were supported to visit family members regularly at home. There were areas within the centre and on the campus grounds to meet with visitors, including the gardens and restaurant.

Judgment: Compliant

Regulation 17: Premises

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

The purpose-built bungalows had the same layout and were accessible to residents living in the centre. Some minor maintenance issues required attention, such as worn cupboards in residents' bedrooms and peeling office furniture. However, these were already identified on the centre's maintenance log and had been escalated to management.

Judgment: Compliant

Regulation 28: Fire precautions

There was a fire evacuation procedure in place for the campus. Fire doors in the centre were controlled by electro-magnetic hold-open devices that automatically shut on the activation of the fire alarm. One fire door had been identified for review to ensure resident accessibility and independent operation. An emergency bleep system connected the fire panels in each building. The fire panel was easily found in the staff office.

The person in charge had prepared evacuation plans to be followed in the event of the fire alarm activating, and each resident had their own individual evacuation plan which outlined the supports they required in evacuating. Fire drills, including drills reflective of night-time scenarios were carried out to test the effectiveness of the evacuation plans.

Residents' emergency evacuation plans provided guidance to staff on the order of evacuation based on the location of the fire and residents' assessed needs.

Night-time drills required the support of staff from adjacent bungalows. A review of fire drills revealed that residents could be evacuated in a timely manner, indicating that fire evacuation procedures were effective. Recorded fire drills clearly demonstrated the supports used during the drill, for example, the type of transfer used and the number of staff required.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs had been completed for each resident. They also had a personal plan, which was reviewed at least annually. There was evidence of regular multidisciplinary input into and review of the supports provided to the residents.

The inspector reviewed a sample of files and noted that support plans were in place for all identified issues. Support plans were found to be individualised, person centered and provided clear guidance for staff.

However, for one resident within the centre, due to the complexities associated with their recent diagnosis and previous history, the centre was not fully meeting all their assessed needs. The provider had made good efforts to gain support from health and social care professionals as aspects of care and support required this input for this resident. Plans to renovate this resident's living environment were at a planning and design stage.

Judgment: Substantially compliant

Regulation 6: Health care

Healthcare was well managed, and both long-term conditions and changing needs were responded to appropriately. There were detailed healthcare plans in place that included appropriate guidance for staff; for example, a care plan for the management of epilepsy gave guidance for the long-term management of the condition and also for care interventions in the event of a seizure. There was evidence that these care plans were implemented and that the interventions were recorded daily where appropriate.

Staff were knowledgeable around these supports and kept daily records in relation to residents health care needs as required. These plans were being reviewed to ensure that the care provided was effective.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were several restrictive practices implemented in the centre, including environmental, physical, and rights restrictions, such as locked doors and sensor alarms. There were arrangements to ensure that the restrictions were implemented in line with best practices. The person in charge maintained a restrictive practice register, and the provider's human rights committee approved all restrictive practices. The service demonstrated a commitment to minimising the use of the restrictions in the centre.

Training had taken place in relation to residents' rights and promoting a restraint-free environment. Each restrictive practice had a rationale, risk assessment and evidence of alternative lesser restrictive options trialled. For example, one healthcare condition had three restrictive practices applied, but it was evident as to why all three were required. The inspector found good bedrail management, including servicing records and knowledge of potential risks such as engagement and entrapment. The inspector met with a member of the maintenance department who maintained a register of all equipment that required servicing, including bed rails. On visual inspection, these were maintained to a high standard, and staff regularly completed checks to ensure they adhered to best practices.

The inspector reviewed documentation relating to two areas of improvement that the provider had identified. Bedrooms had windows with blinds, which required review for residents who could not independently operate the blinds. A contact adhesive had been ordered for these rooms. Also, the use of window restrictors was currently under review in the centre for risk rationale. In addition a specialised remote had been purchased for a resident who previously, due to identified risks, could not independently operate a television.

The use of proactive helmets in the centre had not been identified as a restrictive practice and required review.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had systems in place to support staff in the identification, response, review, and monitoring of any safeguarding concerns. All staff had completed training in safeguarding vulnerable adults. Safeguarding protocols were in place for identified potential risks, and safeguarding plans were implemented for active safeguarding concerns. Safeguarding was regularly discussed with staff, including at the monthly team meetings as an action from a quality review. On reviewing

safeguarding events in the centre, there was a reduction in the number of incidents in 2024 compared to 2023. Nineteen safeguarding concerns had been reported in 2023, with six having been notified to date in 2024.
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 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glen 3 OSV-0003727

Inspection ID: MON-0036234

Date of inspection: 06/06/2024

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. • Since the inspection 2 full-time nurses have commenced in the designated centre. 3 further staff are currently in the final stages of recruitment. • A care staff advert is currently in place to recruit the care staff vacancies. This advert and future adverts have full-driving licence and willingness to drive as an essential criterion. • The provider will ensure that regular relief staff will be assigned to fill vacancies. • A review of drivers in the designated area is being undertaken by PIC/PPIM to ensure evenly distributed. • New vehicles are being allocated to the campus, with some of these being automatic, which will increase the number of staff able to drive them. • The provider will ensure that access to taxis will continue to be available should there be difficulty accessing service transport.	
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	

• ALBAC & Ski sheet training schedule in place, all staff to be completed by 31.08.24.

• PIC has scheduled staff to complete feeding, eating, drinking, and swallowing difficulties on HSEland by 31.8.24.

• 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.

• PIC has booked staff on basic life support training throughout the year.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The PIC will continue to liaise with the person, their family and the MDT with regular meetings to support their assessed needs.

• Plans to develop this resident's living environment are progressing as planned with expected completion date of December 2025.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The use of a proactive helmet for one resident has been reviewed and documentation in place as per restrictive practice policy.

• The PIC / PPIM will continually review practices in the designated centre in line with the restrictive practice policy.

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	31/08/2024
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that	Substantially Compliant	Yellow	31/12/2025

	arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/08/2024