

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Glen 1
Centre ID:	OSV-0004907
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Provider Nominee:	Michael Stokes
Lead inspector:	Louise Renwick
Support inspector(s):	Helen Thompson
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 15 May 2017 09:15 To: 15 May 2017 19:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This was the second inspection of this designated centre which had been registered in November 2015. It was an unannounced inspection that was conducted in line with HIQA's remit to monitor ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The action from the previous inspection in relation to staffing resources was followed up on as part of this inspection.

Description of the service:

The centre was situated in a suburban campus setting, close to a large park with amenities and to a local village. The centre catered for 18 residents and was comprised three bungalows. Each bungalow provided single room occupancy for residents. Garden areas were available for residents' usage. There was also a restaurant and day service facility on site.

How we gathered our evidence:

Inspectors spent time in all three units of the centre, met with residents and staff and observed interactions. Inspectors met a number of staff but spoke specifically with four staff members, two clinical nurse managers and the person representing the provider. Inspectors also had the opportunity to speak with a family member during the course of the day. Documentation was reviewed such as incident records,

personal plans, contracts, risk assessments and minutes of meetings.

Overall findings:

Inspectors found compliance in healthcare needs and non-compliance in the other six outcomes inspected. Inspectors found that while the healthcare needs were well met by a nursing led model of care, the campus based environment was having a negative impact on the social needs and community inclusion of residents. Staffing issues were evident with an over-reliance on the security and support of other designated centres on campus to provide cover for some nursing needs and emergencies. Some units only had one staff on duty from the late afternoon for six residents with high dependency needs and dementia which resulted in poor activation and occupation for residents and limited their ability to have choice and control over their lives. Inspectors observed that residents appeared content and comfortable in their home, but had limited occupation during the day. Families and staff who spoke with inspectors also expressed that while residents' health needs were being well met, their opportunities in the evenings were limited, and this was impacting on them socially and in meeting their personal goals.

Deputising arrangements were in place for the absence of the person in charge. Inspectors did not have the opportunity to meet the person deputising due to training commitments. Inspectors found that the management systems in place to monitor the quality and safety of care and support was in need of improvement as audits, reviews and current systems were not effectively capturing areas in need of improvement.

The findings of this inspection are outlined below, with areas in need of improvement identified in the action plan at the end of the report.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors met with residents and staff during the inspection and observed practice in the designated centre. Inspectors also had the opportunity to meet with some family members.

Inspectors found that the privacy and dignity of residents in respect of their information and documentation was not fully promoted. Information about other residents was included in some personal files. Similarly, language used during inspection and within documentation did not fully uphold the dignity and respect of residents in line with best practice. For example, using phrases such as "toileting", "feeding" and "cot-sides". That being said, interactions observed in the three units of the centre between residents and staff was very positive and warm, and tasks were carried out in a caring manner.

Inspectors found that residents' ability to make choices and have control over their daily lives in respect of their activation, their access to the community and the achievement of personal goals was inhibited due to the centre being operated based on resources available instead of a person centred approach. The centre was located on a campus with other designated centres, day services and a restaurant. While this offered a community type environment it inhibited the amount of access residents had to external facilities, and access to the community. The achievement of residents' personal goals were limited by the low levels of staffing available in the evenings and weekends in the centre. For example, some units had one staff on duty in the afternoon and evening to support six residents. This affected residents ability to choose how to spend their evenings, and even to choose when to require support for basic tasks such as personal care, as they were reliant on the staff to call upon the assistance of other staff from

different designated centres located close by.

Inspectors reviewed documentation and found that a resident had purchased a specialist chair that cost a significant amount of money. Allied healthcare professionals had assessed the resident for this in 2014 and deemed it a necessary tool for the residents care and support. Inspectors enquired as to the reason for the resident purchasing this item out of their own funds, as their recent contract indicated that specialist items would not be at the expense of the residents if deemed necessary. The provider endeavoured to follow up on this post inspection.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the assessment and planning documentation for residents living in the centre and spoke with staff regarding residents' care plans and personal plans.

Inspectors found that while there was a system in place for the assessment and planning of healthcare needs, the social and personal needs of residents were not effectively assessed, planned for and achieved.

Inspectors were told that some residents were in the process of awaiting a new meeting to discuss their social and personal goals. Inspectors reviewed a sample of person centred plans and found that some goals had been set in 2014 and 2015 and were still in place for residents. However, to date some of these goals had not been fully achieved or progress reported on in that timeframe. For example, to improve contact with family, or to avail of public transport. If a goal had not been worked on or achieved, alternatives had not been sought or considered.

Inspectors also found that there was a disconnect between what residents were indicating they wanted to achieve, the advice of other allied health professionals and the

daily activities in place in the centre. For example, in order to promote more positive behaviour a resident's goal was to be more independent. However, no activities on a daily basis were linked to improving these skills. The resources of the centre also were not encouraging this, with meals prepared from a central canteen, and household staff employed to clean and launder clothing.

Inspectors found that residents had poor opportunities to engage socially within the local community, and were limited in their ability to experience new opportunities based on the staffing levels and manner in which the centre was operated. While there was a weekly plan of activities for the campus, and some of these externally run activities were of benefit and enjoyed by residents, there was a focus on in-house activation. For example, music, arts and crafts, reflexology, physio-fit were all held on-site in a day services room. Even with the provision of these group activities, some residents had no planned activation in a given day, or only had the opportunity to attend one hour a day of an activity on site.

Staff spoken to felt that they were limited in supporting residents to achieve their goals, and to engage in the community due to the current staffing levels in the centre.

Inspectors found that overall, improvements were required to ensure the social and personal needs of residents were effectively assessed, planned for and reviewed, and that residents had equal opportunities to engage with their community and lead a social life of their choosing.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors spoke with staff members and family members who outlined that they felt residents were safe in the designated centre, and the premises and environment promoted this. Inspectors found that the health and safety of residents, staff and visitors was promoted, but further improvements were required in relation to the review and learning from incidents, and ensuring timely evacuation in the event of an emergency.

Inspectors reviewed practices in relation to infection control and found that there was appropriate personal protective equipment in place in the centre, including gloves, hand

sanitizer gels and waste disposal. The centre employed specific household staff who managed the laundry and general cleaning and upkeep of the home. Inspectors found the centre to be clean. Any risks associated with infection had been assessed and specific care plans drawn up if required.

Inspectors found there to be a risk management policy in line with the regulations. There was risk register maintained outlining the general environmental risks, along with more individualised specific risks in the centre. However, on review of the log of incidents and accidents inspectors found that the review and learning from incidents did not feed into the review of risk, or escalate issues to ensure learning could be gained, and possible future risks mitigated. For example, staff had obtained an injury from using a piece of evacuation equipment in April. However, this had not fed into a review of its use, or identified any learning or possible changes required to ensure it did not happen again. On discussion with staff, inspectors found that not all staff had been trained in the use of the equipment, and records showed that previous issues had been identified regarding difficulties in their use. On review of training records, inspectors noted a number of staff whose training in safe manual handling had expired, some of which had expired a significant length of time ago. The gaps in training had not been considered or assessed from a risk perspective.

Patterns identified by inspectors in the review of incidents and accidents had also not resulted in the assessment of risk. For example, in respect of unexplained bruising and the making of false allegations.

Inspectors found there to be fire safety systems in place in the three units of the designated centre and an evidenced system of checking and servicing of the fire detection and alarm system along with the emergency lighting. Fire extinguishers were in place in the centre, and evidenced as serviced routinely by a relevant professional. Staff had been provided with training in fire safety, but not all had experience in the use of a piece of equipment to evacuate residents from a bed.

There were fire doors throughout the building. Inspectors found that some fire doors were held open, and as such could not be released in the event of an alarm activation. Inspectors reviewed minutes of health and safety meetings, and management meetings going back to October 2016 which highlighted this as an issue and the need for some doors to have automatic magnetic releases. However, these were not available on all fire doors, and some were found to be wedged open during the inspection.

Inspectors were also concerned regarding the ability of the staff team to safely evacuate the building in a timely manner. Inspectors found that fire drills had been carried out. However, some of these drills had taken considerable time to evacuate residents, and not all residents had been successfully supported to evacuate. For example, one drill took eleven staff over 30 minutes to evacuate, and records showed that one resident had remained inside. Previous drills indicated that not all residents would leave the premise also. On review of documentation, inspectors found that there was a lack of a fire drill to show that the lowest number of staffing could safely evacuate the highest number of residents. Inspectors were not assured that effective systems were in place to ensure the safe and timely evacuation of all residents in the event of a fire or required evacuation, and requested the provider to review this post inspection.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The provider had ensured there were policies to guide practice in relation to the prevention, detection and response to abuse, the provision of intimate care, the management of behaviour, the use of restraint and the safe recruitment and vetting of staff. Staff had received training in the protection of vulnerable adults and this was refreshed routinely. Staff outlined that they had undertaken this training, and family members told inspectors that they felt their relatives were safe living in the centre.

A number of allegations of abuse had been notified to HIQA back in October 2016 in relation to negative interactions between peers. On review of these notifications inspectors found that the appropriate steps as outlined in the centre's policy and national policy had been followed. For example, a preliminary screening was done, safeguarding plans put in place and practical steps taken to prevent negative experiences between residents living together. However, on review of the incident log inspectors found a lack of a consistent approach to the reporting and management of peer to peer issues. For example, some incidents had been notified to HIQA and a preliminary screening conducted along with an interim safeguarding plan, while others had been recorded as an incident but not viewed as an allegation or concern of peer to peer abuse. While this was in need of address to ensure consistency, peer to peer issues were not common place, and issues reviewed had been resolved with appropriate supports put in place for residents involved.

Inspectors found that there had been a number of unexplained marks and bruises that had not been considered within a safeguarding context. For example, an unexplained bruise on a resident's inner thigh had not resulted in a screening to determine if there was any cause for concern, or need for further review. While probably reasons for their occurrences were assumed due to manual handling or poor mobility of residents, the process around the monitoring of unexplained bruises required improvement to ensure a

proactive approach to the protection of residents.

Inspectors were told that some residents living in the centre presented with "challenging behaviour". On speaking with staff and reviewing residents plans, inspectors found that residents had plans to guide staff on how to respond or react at times of crisis or negative behaviour. Some residents had coping strategies written up by staff members which were seen to be in place on the day of inspection. For example, the use of a visual timetable to assist a resident to be familiar with the routine of the day. While other residents' coping strategies were not put in place and required more input. Inspectors found a lack of a comprehensive analysis of why residents presented with certain behaviours and effective proactive plans to manage this effectively. For example, some plans highlighted the need for structured routine during the day, but as mentioned in this report residents' access to meaningful activities and to the community were not fully realised due to the staffing levels and manner in which the centre was operated. The input from members of the multidisciplinary team were not consistently included in plans to support residents with their behaviours. For example, speech and language support. On review of training records, inspectors found that staff required training in the positive management of behaviour.

Inspectors reviewed the restraint register in the centre, and reviewed the quarterly notifications that are submitted to HIQA and outline any restraints in use. Inspectors found that a restraint free environment was promoted in the centre. Restrictions were minimal and anything in use had been risk assessed for the safety of residents. For example, the use of bed rails and lap belts.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that residents' healthcare needs were met in the designated centre and positive health promoted. The designated centre was predominately a nurse-led centre, with a management team consisting of clinical nurse managers and a local team of staff nurses and healthcare assistants.

Residents had access to a General Practitioner (GP) who visited all designated centres on the campus on a weekly basis. Residents also had access to other allied health

professionals such as dentist, chiroprapist, occupational therapist and a physiotherapist. Some activities that were held centrally on the location were focused on promoting healthy living. For example, exercise classes run by physiotherapists to promote mobility. A new initiative on getting fit was beginning for a five week period to encourage healthy living.

Staff and family members felt that residents' health needs were well monitored in the designated centre. Inspectors found evidence of good and consistent assessments of healthcare related issues, along with nursing interventions and care plans to address any area of healthcare or any health risks. For example, short term care plans for infections and care plans for constipation.

Inspectors found that main meals were prepared by a central canteen and transported to the centre in a heated trolley. While this hampered residents involvement in the preparation and experience of meals cooking in their home, inspectors found that the food provided was healthy and nutritious. Diets were modified based on the needs of residents. For example, if there were issues with chewing or swallow. Inspectors were told by staff that some food was prepared in the centre. For example, breakfast and some light suppers and staff were encouraged to make a breakfast brunch some weekends for residents. Residents who required it had access to a dietitian.

Judgment:

Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that there was a clear and known management structure in the designated centre. Since January 2017 there had been a newly appointed services manager who acted on behalf of the provider and the people in charge of three designated centres in this location reported to him. There was an appointed person in charge of this centre, who was on extended leave at the time of the inspection, and this had been appropriately notified to HIQA and arrangements had been put in place for the management of the centre during this absence. Inspectors did not meet the person

managing the centre in the absence of the person in charge on this occasion, as they were on a training course. Inspectors could not determine the hours worked by the manager, as they were not reflected in the roster for the centre, but inspectors were told that this person worked in a full time capacity over the seven days of the week, and was supernumerary to the roster.

Inspectors found that the provider could not show evidence of an unannounced visit in the centre since May 2016. Inspectors found that an annual review was completed in October 2016. This report reviewed any actions arising from the previous HIQA report, along with any areas identified for improvement in the unannounced visit of May 2016. The annual review also took into consideration the views and opinions of some family members and residents, and consisted of an action plan to ensure progress against improvements were monitored.

While this review highlighted some of the areas noted through this report in regards to the need for more community integration it did have clear actions in relation to the staffing numbers. While it identified the need for the staff team to be consistent and to limit the use of unfamiliar agency, and highlighted that rosters had been made more flexible, it did not address the low numbers available in some units as indicated at the previous inspection or show any future plans to address this. Similarly, the action plan from the unannounced visit in May 2016 laid no mention to the need to review the staffing levels in the centre.

Staff meetings were held regularly within each unit of the centre, and minutes were recorded. A health and safety group also met on regular basis to discuss health and safety issues around the campus. There was a process in place for the management team to meet monthly with the provider. This was documented and recorded. While these meetings were routinely held, they were operational in nature and did not fully capture systems in need of review or escalate areas of risk, incidents or concerns. For example, there had been a number of medication errors over a six month period that were not reviewed at a system level or documented progress of steps being put in place to alleviate them. Similarly, fire drills that had not been successful had not been escalated to these meetings or health and safety meetings to ensure they were adequately reviewed at the management level. Inspectors were not assured that the oversight or the management systems in place were fully capturing or managing issues of risk or areas in need of improvement as they arose.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that at times there were insufficient staff available to meet the needs of the residents in the centre. This was a finding at the previous inspection of July 2015 and had not been adequately addressed.

Inspectors found that the staffing levels were not consistently sufficient to meet residents' needs. For example, residents' social care needs were not always being supported, access outside of the campus was limited, and residents' who required the assistance of two staff for personal care did not have it readily available in the evenings. As mentioned in the summary, inspectors found that there was an over-reliance on the support of other centres located on site to give nursing support, or support of a second staff to deliver personal care. Similarly, it was observed at times that household staff were asked to supervise residents while staff were doing other tasks. The provision of an adequate number of staff across all units was not evident to deliver care beyond the basic level, and to ensure choice and control were promoted and that residents' personal and social goals could be fully realised.

Inspectors spoke with staff and some family members who expressed concern regarding the staffing numbers in the evening and weekends. Inspectors found evidence of personal goals not being actively worked on or achieved, and this was explained as due to needing increased staffing to support their success. Similarly, inspectors found evidence that meetings to discuss residents' goals had not gone ahead due to staff shortages.

The provider nominee informed inspectors that a recent recruitment drive had been completed to fill any current vacancies in the staff complement. However, while this would address the need for the use of agency staff it would not necessarily increase the number of staff scheduled to work each day in each unit of the centre. This finding was also identified in the previous inspection under resources to which the provider had responded that a review of staffing would be undertaken, and additional funding requested if necessary from the HSE. However, on the day of inspection and on review of rosters, inspectors found that some units in the centre had only one staff on duty from the late afternoon to cater for the needs of up to six residents who were living with dementia and had support needs.

Inspectors reviewed the training records and spoke with staff members about the training available to them. Inspectors found a lack of proactive planning regarding training, which had resulted in some staff members requiring refresher training. For example, some staff that performed patient handling as part of their daily work had not completed training in safe manual handling since 2012. The provision of training and refresher training in manual handling, safeguarding of vulnerable adults and behaviour support were in need of address by the provider.

Judgment: Non Compliant - Major

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Company Limited by Guarantee
Centre ID:	OSV-0004907
Date of Inspection:	15 May 2017
Date of response:	15 August 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Language use was not fully promoting of residents dignity.
Information regarding residents was not securely maintained.

1. Action Required:

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Under Regulation 09 (3) you are required to: 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.

Please state the actions you have taken or are planning to take:

1. The PIC will complete the annual review of care plans as per the Glen 1 audit schedule-
2. The PIC will ensure all personal information about service users remain in individuals file. All care plans were reviewed and ensured that only residents information was kept in there own file.
3. The PIC will ensure this is put as agenda item at the next team meeting to remind staff of securely maintaining information.
4. The provider nominee circulated a memo to staff teams on the 17.05.17 to bring this to the attention of all staff members.

1. 31.07.17.
2. 31.07.17
3. 31.07.17
4. 17.05.17 Completed

Proposed Timescale: 31/07/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Based on the resources in the centre residents were not encouraged to have choice and control over their daily lives.

2. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:

1. Workshops held on the good life to provide staff an understanding and background to Person Centred Planning on the 29.03/17,05/04.17 /19.04.17.
2. Person Directed Planning training held for keyworkers on the 21.06.17 and on the 29.06.17 further training scheduled
3. The provider nominee together with the human resource department are working together to ensure staff vacancies are filled, on-going recruitment for the centre is continuing; interviews for care assistants took place 14.02.17,24.03.17 &27.03.17, CNM1 interviews 22.03.17, staff nurse interview 21.03.17. Recruitment drive for nurses (intern student nurses) took place 22.03.17 & interviews took place on 03.05.17.
4. Provider nominee &PIC to carry out a skill mix review and look at sample rosters to ensure sufficient staff are available to meet residents assessed needs.

1. 19-04-2017 completed

2. 31-10- 2017
3. 31-10-2017
4. 30-09-2017

Proposed Timescale: 31/10/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The social care and personal needs of residents were not annually assessed and planned for.

3. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:

1. The PIC will ensure a full review of social care needs will be completed for residents. PIC to meet with day service co-ordinator and keyworkers to review the quality of life recording sheets establishing the current baseline for community presence and participation.
2. Yearly schedule completed for care plan audits to be carried out
3. The PIC will ensure that the key worker, day service co-ordinator & resident representatives evaluate these goals on a periodic basis. This will be done through Person Directed Planning meetings set for the 21.06.17 and the 29.06.17. The first step of the assessment and planning of specific social care needs are to be completed by 31.08.17.
4. Person directed planning training scheduled for keyworkers on the 14.06.17 and the 29.06.17.

1. 31.08.17
2. 31.07.17
3. 31.08.17
4. 31-10-2017

Proposed Timescale: 31/10/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Personal plans were not reviewed to ensure they were effective and goals were being

achieved to bring about improvements in residents quality of life.

4. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:

1. Commencement of staff training (The Good Life) with regards to personal directed planning and social role valorisation. Training took place on the 29.03.17/05.04.17 /19.04.17. follow on training on PDP planning held on the 21.06.17 with further date scheduled for the 29.06.17.
2. New template of a monthly data report will inform the PIC the status of goals for residents, commenced March 2017.
3. Monthly goal tracking form will be part of the Person Directed planning and in place for 6 residents

1. 31-10-2017
2. 04.07.17 completed
3. 31-10-2017

Proposed Timescale: 31/10/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

While risk management systems were evident, the review of incidents did not feed into the on-going assessment of new or possible risks.

5. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

1. The PIC will ensure monthly data is completed which will highlight red risks for that period. HS003 and HS006 forms will identify this.
2. Monthly service quality and risk meetings held to discuss these items with outstanding items remaining on the agenda. Last meeting held on the 19.06.17.
3. The PIC will review the current Risk Register and ensure an ongoing review of risks is carried out and reflected in risk register to ensure learning from events and possible future risks mitigated. Incident report and risk assessments will be reviewed and the PIC will respond in a timely manner.

1. 04.07.17

2. 17.07.17
3. 31-07-17

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The arrangements for containing fire were not adequate. i.e Not all fire doors could close in the event of the alarm sounding.

6. Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:

1. The PIC along with the provider nominee will carry out a full review of fire evacuation within Glen 1 and look at alternative options to ensure a safe and timely evacuation for all residents.
2. Provider nominee circulated memo to staff teams on the 17.05.17 regarding fire doors being held open to cease immediately.
3. Automatic door closures have been put in place in four bedrooms- 17.05.17.
4. Health and safety officer appointed for Glen 1 who will attend monthly health and safety meetings and bring items of concern forward for Glen 1.
5. The PIC will ensure this is put as an agenda item at the next team meeting.

1. 12.07.17.
2. 17.05.17 completed
3. 17.05.17 completed
4. 27.04.17 completed
5. 31.07.17

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Arrangements for the safe evacuation of all residents in the event of a fire required review.

7. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:

1. Fire evacuation review meeting held with the director of logistics on the 23.06.17 to review fire evacuation in Glen 1.
2. A full fire evacuation took place on the 29.05.17.
3. PIC to research alternative evacuation equipment. Trial use of hoist carried out on the 26.06.17 as well as reviewing the use of an Albac mat
4. PIC to schedule training for staff in the use of ski sheets.
5. The PIC will ensure a planned night evacuation is completed at minimum numbers.

1. 23.06.17 completed
2. 29.05.17 completed
3. 27.06.17 completed
4. 31.07.17
5. 31.07.17

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Fire precautions were not adequately reviewed to ensure their effectiveness.(i.e that fire doors could release, fire drills were successful and ensured safe evacuation, or that training was adequate for the equipment in use.)

8. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:

1. The PIC will ensure a full review of the fire folder is completed.
2. The PIC will review fire evacuation for each individual-PEEPS
3. The PIC will arrange for training to be provided to staff on the use of ski sheets.
4. Fire drills to be reviewed and a full fire drill was completed on the 29.05.17.
5. Automatic door closures have been fitted in four bedrooms- 17.05.17.

1. 12.07.17
2. 12.07.17
3. 31.07.17
4. 12.07.17
5. 17.05.17 completed

Proposed Timescale: 31/07/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

All staff did not have appropriate training in the positive management of behaviour and positive interventions.

9. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:

1. PIC will review training records and highlight staff members for priority training to education department.
2. PIC will complete a training needs analysis for 2017.
3. Referred resident to CNS for support who will assist in reviewing the protocols in place.

1. 30.06.17 on-going
2. 30-09-2017
3. 19-07-17

Proposed Timescale: 30/09/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Efforts to identify and alleviate the causes of behaviours were not in place for residents identified as presenting as challenging.

Resident who had been identified as being challenging did not have appropriate proactive interventions to reduce them.

10. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:

1. The PIC will send a referral to CNS in positive behaviour support for further input to identify cause of behaviour.
2. The PIC will refer to speech and language to look at resident's augmentative communication.
3. Restrictive practice meeting held every three months to review all restrictive practices in place. Next review September 2017.

1. 19.07.17

2. 19.07.17
3. 06.06.17 completed Next review 20th September 2017

Proposed Timescale: 20/09/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Unexplained marks and bruises were not reviewed or considered under the policy on the protection of vulnerable adults.

11. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:

1. The PIC will ensure all incidents of unexplained marks or bruising is reported as per policy.
2. The PIC will ensure this is on the agenda for discussion at the next team meeting.
3. Safeguarding officer OR Provider Nominee will be invited to team meeting to provide staff with awareness training on reporting.

1. 15.05.17
2. 31.07.17
3. 31.07.17

Proposed Timescale: 31/07/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Management systems in place were not consistently monitoring risks, incidents or quality and safety issues as they arose.

12. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

1. Service Quality and safety meeting where Key issues are discussed such Risk Registers, Fire safety, medication errors

2. PIC to review risk register in designated centre.
3. H&S Meeting held on the 30-05-2017
4. PIC will ensure all incident report forms are reviewed and reflected in risk register.(Quarterly Reviews)
5. The PIC will ensure any escalated risks are sent to the provider nominee and discussed at the Service Quality and Safety meeting.

1. 19.06.17
2. 31.07.17
3. 30.05.17 completed
4. 30.06.17
5. 19.06.17

Proposed Timescale: 31/07/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no evidence of an unannounced visit to the centre since May 2016.

13. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:

1. The registered provider will ensure the six monthly provider nominee inspection is completed and a full report will be sent to the PIC for an action plan to be developed.

Proposed Timescale: 31/07/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Numbers of staff on duty was not adequately meeting residents' needs.

14. Action Required:

Under Regulation 15 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:

1. The provider nominee together with the human resource department are working together to ensure staff vacancies are filled, on-going recruitment for the centre is continuing; interviews for care assistants took place 14.02.17,24.03.17 &27.03.17, CNM1 interviews 22.03.17, staff nurse interview 21.03.17. Recruitment drive for nurses (intern student nurses) took place 22.03.17 & interviews took place on 03.05.17.
2. Provider nominee &PIC to carry out a skill mix review and look at sample rosters to ensure sufficient staff are available to meet residents assessed needs.
3. The PIC will carry out a review of the statement of purpose to reflect the current needs of the residents living in Glen 1.
4. To meet with PIC'S to increase /decrease the WTE for each house based on the assessed needs of residents
5. Meeting with CEO to review WTE and resources
6. Meeting with HR to review WTE and skill mix and staff grades within the house and centre
7. To review rosters in each house to look at start and finish times for staff
8. Meeting with PIC for Glen 1 to ensure minimum staff on duty to meet the assessed needs of the residents
9. Staff to be available to meet the needs of residents to be discussed at staff meeting
10. On the completion of the review of the skill mix within the houses any identified changes to the current skill mix to be discussed further with HR and Director of Finances
11. 5.90 WTE staff nurse filled awaiting Interns to commence September 2017
12. HCA interview completed 21-07-17 to fill 1.73 WTE vacancy no further HCA Vacancies

31-10-17

2.30.09.17

3.30.09.17

4. 16-08-2017

5. 25-07-2017 (completed)

6. 01-08-2017 (completed)

7. 24-07-2017 (completed)

8. 24-07-2017 (completed)

9. 09-08-2107 (completed)

10. 31-12-2017

11. 30-09-2017

12. 21-07-2017 (completed)

Proposed Timescale: 31/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all staff had up to date training.

15. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

1. The PIC will ensure a full review of staff training records carried out. Provider nominee and education & training co-ordinator informed of priority staff who require training and refresher training.
2. PIC will complete a training needs analysis for 2017.
3. The PIC will ensure that staff are prioritised and scheduled to attend when advised of training and refresher dates provided by the Education department.

1. 30.06.17 on-going
2. 30.09.17
3. 15-05-17
4. 16-08-2017
5. 25-07-2017 (completed)
6. 01-08-2017 (completed)
7. 24-07-2017 (completed)
8. 24-07-2017 (completed)
9. 09-08-2107 (completed)
10. 31-12-2017
11. 30-09-2017
12. 21-07-2017 (completed)

Proposed Timescale: 31/12/2017