Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Glen 3
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	14 May 2019
Centre ID:	OSV-0003727
Fieldwork ID:	MON-0026965

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 adult ladies 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. The centre is nurse led and 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. 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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
14 May 2019	09:30hrs to 17:50hrs	Marie Byrne	Lead

Views of people who use the service

The inspector had the opportunity to meet and briefly engage with 15 of the 16 ladies living in the centre during the inspection. One of the ladies expressed her opinion in relation to the quality of care and support in the centre by informing the inspector that she was happy and felt safe in her home. The remaining ladies in line with their needs and wishes did not express their opinions verbally to the inspector. Throughout the inspection, residents appeared comfortable with the staff and the support they were offered. The inspector also observed staff encouraging residents' independence and supporting them to make choices in line with the needs and wishes.

Residents and their representatives views were captured as part of the latest annual review of the centre. Feedback in this report was positive in relation to care and support in the centre.

Capacity and capability

Overall, the inspector found that the registered provider and person in charge were not ensuring that all residents in the centre were in receipt of a good quality and safe service. The inspector found that a number of actions identified by the provider following the last inspection had not been implemented and this was leading to poor outcomes for some residents. These will be detailed further in the report. This unannounced inspection was carried out following receipt of information to the Office of the Chief Inspector (OCI) regarding the quality and safety of the care delivered in this centre.

Although there were clear management systems and structures in place and staff had clearly defined roles and responsibilities, they were not proving effective as they were not ensuring full oversight of the services due to their failure to act on key concerns which were impacting negatively on residents' experience of service provision. There was evidence that the person in charge and person participating in the management of the designated centre were striving to ensure that residents were in receipt of good quality of care and support in the centre and that they had systems in place for oversight and monitoring in the centre. They were completing audits and following up on required actions. There was evidence that they were present and supporting residents and staff in the areas regularly. They were meeting regularly and had systems in place to review incidents and to share learning following these. However, not all incidents in the centre were being escalated for their review in line with the organisations' or national policy.

The staff team reported to the person in charge who in turn reported to the person participating in the management of the designated centre (PPIM). The inspection was facilitated by the person in charge, clinical nurse manager and service manager. Throughout the inspection, they were found to be knowledgeable in relation to residents' care and support needs. In addition, the residents were familiar with them and appeared very comfortable in their presence.

The annual review of care and support had been completed and there was evidence that some actions following this review were progressing. However, in line with findings during the inspection, some had not progressed and this was leading to negative outcomes for residents in relation to the premises not meeting their needs and measures in place to keep them safe. The latest six monthly review of care and support in the centre had been completed and some of the findings were similar to that of this inspection. There was evidence that some actions from this review were progressing in line with timeframes identified by the provider. The inspector acknowledges that the timeframe for completion of some of these actions had not yet passed.

The provider had recognised that the staffing levels in the centre were not appropriate to meet residents' assessed needs and had commissioned a full review of this. At the time of the inspection, they were awaiting the report from this review. In line with the findings of this inspection, the receipt of this report and the review of its findings needed to progress in a timely manner. In the absence of this report there was evidence that the service manager and person in charge were attempting to allocate staff from within their existing resources, to areas where residents' safety was a priority. However, this was not always possible which was leading to times where staffing levels were not in line with residents' assessed needs.

In addition to the fact that current staffing numbers were not meeting residents' needs, there were a number of staffing vacancies in the centre. These vacancies included 0.5 whole time equivalent (WTE) vacancy for a clinical nurse manager, 1.5 WTE staff nurse vacancies and 1 WTE household vacancy to cover leave. Through discussions with staff, meeting residents and on reviewing documentation, it was evident that consistency of staff was particularly important in the centre in line with residents' needs. The inspector acknowledges that the provider was aware of this and were attempting to minimise the impact of staffing vacancies for residents by using regular relief and agency staff while they were in the process of recruiting new staff.

Staff had completed training and refreshers in line with residents' needs. Some staff had been identified as requiring additional training to support residents with their assessed needs and the person in charge gave assurances to the inspector that this training was being organised. A number of staff who spoke with the inspector were highly motivated and knowledgeable in relation to residents' needs. They were in receipt of formal supervision. However, these were not occurring in line with identified timeframes. The person in charge had plans to schedule more regular formal supervision sessions with staff, once the clinical nurse manager vacancy was filled.

Regulation 15: Staffing

There were not sufficient staffing numbers in the centre to meet the number and needs of residents. The provider had recognised this and was in the process of recruiting to fill existing staffing vacancies. In addition, they had completed a full review of residents' dependency needs and were awaiting the report from this review to inform the required staffing numbers to meet residents' current assessed needs.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to training and refreshers in line with residents' needs. In addition, the person in charge had identified a need for a number of staff to complete additional training in line with residents' needs. Staff stated they were supported in their roles and were in receipt of formal supervision. However, this was not been completed in line with identified timeframes and the person in charge had plan in place to put a revised supervision schedule in place.

Judgment: Substantially compliant

Regulation 23: Governance and management

Although there were clearly defined management structures which identified the lines of authority and accountability for each staff member, they were not not proving effective due to lack of progress in relation to the providers failure to act on key concerns which were impacting negatively on residents' experience of service provision.

Judgment: Not compliant

Regulation 31: Notification of incidents

A number of allegations, suspected or confirmed of abuse had not been notified to the OCI in line with the requirement of the regulations.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the provider and person in charge were striving to ensure that the quality of the service provided for residents was good. However, they were failing to act on key actions identified by themselves to improve outcomes for residents in relation to the quality and safety of care and support in the centre. These actions included planned works to ensure the design an layout of the premises was meeting residents' needs and the implementation of safeguarding measures to keep residents' safe.

Overall, the centre was found to be clean, warm, comfortable and homely. Residents' bedrooms were decorated in line with their needs and preferences and they had access to private and communal space to meet their needs. However, in line with the findings of the last inspection, the centre was not designed and laid out to meet the number and needs of all residents in the centre. The majority of residents had free access to all areas of their home. However, one resident did not have access to all areas of their home, which included bathroom and kitchen facilities. In line with the findings of the previous inspection, the resident had to get the attention of staff in order to access bathroom or kitchen facilities. The inspector observed staff supporting this resident in line with their requests for support. However, this was dependent on the staff completing regular checks and being visible to the resident when they needed their support. The provider had submitted a compliance plan to the Office of the Chief Inspector (OCI) on 08 June 2018, stating that these planned works would be completed by 31 March 2019. However, these required works had not been completed at the time of the inspection in line with an additional condition of the registration of the centre. The provider sent confirmation following the inspection that the planned works had commenced on 20 May 2019.

There were a number of restrictive practices in the centre and there was evidence that these were assessed and reviewed regularly. Staff had the up-to-date knowledge and skills to support residents' assessed needs and residents had access to the support of relevant allied health professionals in line with their needs. There was evidence that their support plans were reviewed and updated regularly.

Residents were protected by appropriate safeguarding policies in place and staff had access to training to support them to carry out their roles and responsibilities in relation to safeguarding residents. Staff who spoke with the inspector were knowledgeable in relation to their responsibilities in relation to immediate actions to keep residents' safe and in relation to reporting and documenting allegations or suspicions of abuse. However, due to staffing numbers in the centre it was not always possible to implement some residents' safeguarding plans. It was clear that staff were attempting to be vigilant and that the person in charge and PPIM were attempting to prioritise staffing resources to keep residents' safe.

However, there were occasions that the residents' safeguarding plans could not be fully implemented. In addition, staff were not recognising some incidents or reporting them in line with the organisations' policy, or bringing them to the attention of the designated officer or person in charge for review. It was evident that where allegations or suspicions of abuse were brought to the attention of the person in charge that they were followed up on in line with the organisations' and national policy.

There was evidence of consultation with residents in relation to the day-to-day running of the centre. Residents meetings were held regularly and there was an advocacy group who were meeting regularly. There was information on display in the centre in relation to areas such as residents' rights, complaints, and advocacy. Throughout the inspection it was clear that staff were working hard to ensure that all residents' privacy and dignity were respected at all times and that they were supported to make choices and have control over their day-to-day lives. However, as previously outlined, due to the design and layout of areas of the centre this was not always possible.

Regulation 17: Premises

In line with the findings of the last inspection, the design and layout of one of the houses in the centre was not meeting residents' needs. The provider had submitted a compliance plan to the office of the Chief Inspector that these planned works would be completed by 31 March 2019. However, these required works had not been completed at the time of the inspection. The remaining areas of the centre were clean, comfortable, well maintained and meeting residents' needs.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents had access to the support of relevant allied health professionals and there was evidence of regular review of their support plans and risk assessments. Staff had access to relevant training and refreshers to support residents. Restrictive practices were reviewed regularly in the centre and there was evidence that they were attempting to use the least restrictive measures for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

There were polices and procedures in place to protect residents and safeguarding measures being put in place to protect residents. However, not all incidents were being recognised or reported in line with the organisations' and national policy. In addition, due to lack of staffing resources in the centre staff were unable to fully implement safeguarding plans.

Judgment: Not compliant

Regulation 9: Residents' rights

Overall, residents were being supported to participate in decisions affecting their daily lives and were being facilitate to make choices in line with their needs and wishes. However, improvements were required to ensure residents' privacy was protected in the centre and that all residents were facilitated to make choices and have control over their daily life.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Glen 3 OSV-0003727

Inspection ID: MON-0026965

Date of inspection: 14/05/2019

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider will ensure there is enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times. There is an active recruitment process in place to hire staff. Interviews for nursing vacancies have taken place and candidates have been successful and the next stage process of HR under way. The Service has recently received a report from an external Consultant who completed an independent review of the centre. The Service Manager in conjunction with the Director of HR, ACEO, Director of Nursing and PIC are scheduled to meet to assess the feasibility of implementing the recommendations, and determining the associated workplan.	
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 will continue to ensure that staff have access to training and refreshers in line with residents needs as set out in the Training needs Analysis. The PIC will update the supervision schedule and aim to complete supervision of staff in timeframe as set out in policy.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The management structure is clearly defined and identifies lines of authority and accountability. The PIC will ensure these are used when there is a concern of service provision.
Management systems are in place to ensure that the service provided is safe, appropriate to resident's needs and effectively monitored. The Service has recently received a report from an external Consultant who completed an independent review of the centre. The Service Manager in conjunction with the Director of HR, ACEO, Director of Nursing and PIC are scheduled to meet to assess the feasibility of implementing the recommendations, and determining the associated workplan.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC and designates will discuss at team meetings and also discuss individually with staff certain circumstances that will need to be followed under the safeguarding policy. These in turn will then be reported to the Authority by the PIC. All other safeguarding concerns will be reported as per policy and safeguarding plans adhered to. The PIC will ensure all staff keep up to date on safeguarding training.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The planned work has commenced (20-05-19) in the Designated Centre in line with previous compliance plan with clear timeframes for completion. The Registered provider and PIC will submit the relevant documentation for an application to vary within the designated centre.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The PIC and designates will discuss at team meetings and also discuss individually with staff certain circumstances that will need to be followed under the safeguarding policy. These in turn will then be reported to the Authority by the PIC. All other safeguarding concerns will be reported as per policy and safeguarding plans adhered to. The PIC will ensure all staff keep up to date on safeguarding training.
The Service has recently received a report from an external Consultant who completed an independent review of the centre. The Service Manager in conjunction with the Director of HR, ACEO, Director of Nursing and PIC are scheduled to meet to assess the feasibility of implementing the recommendations, and determining the associated workplan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Residents have a right to exercise personal choice in their daily lives.
Residents will be facilitated to make choices in line with their needs and wishes.
Extension work has commenced to an area to provide an ensuite for a resident.
Staff will ensure all residents privacy will be protected and any concerns will be reported and supports put in place as necessary to ensure the privacy of all residents living in the Designated Centre.

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.	Not Compliant	Orange	31/01/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs	Not Compliant	Orange	08/08/2019

	of residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/08/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/01/2020
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	30/05/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/05/2019
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the	Substantially Compliant	Yellow	31/08/2019

	freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	30/05/2019