Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Glen 2
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	03 December 2020
Centre ID:	OSV-0001439
Fieldwork ID:	MON-0025733

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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
Thursday 3 December 2020	10:30hrs to 18:00hrs	Jacqueline Joynt	Lead
Thursday 3 December 2020	10:30hrs to 17:30hrs	Valerie Power	Support

What residents told us and what inspectors observed

On the day of the inspection the two inspectors had the opportunity to meet and engage with 15 residents living in the designated centre. The centre comprised of three houses. In line with infection prevention and control measures in place at the time of the inspection, the inspectors visited two of the three houses and greeted residents and staff for a short time at the door of the third house. For the most part, communication between the inspectors and the residents took place from a two metre distance, wearing the appropriate personal protective equipment and was time limited in adherence with national guidance. Some residents communicated with the inspectors independently, while other residents were supported by staff to talk with the inspector. Where appropriate, residents' views were relayed through staff advocating on their behalf and through Health Information and Quality Authority's (HIQA) residents' questionnaires alongside various other records that endeavoured to voice the residents' opinions.

In one of the houses visited, there was a lively atmosphere when the inspector entered, with the sounds of voices, music and activity coming from the living area of the bright, clean and spacious home. The inspector greeted and spent a short time with the residents there, who were enjoying listening to music, dancing, and playing board games with the support of staff. Staff introduced the residents to the inspector, and appeared to know each resident and their preferences well. One resident had recently moved to the centre, and staff reported that they were settling in well in their new home. The resident appeared comfortable and content among the other residents and staff. A small room adjacent to the living area was set up as a sensory room, with comfortable seating, soft furnishings and an array of colourful lighting. One resident had chosen to spend some time in this sensory room, rather than in the bustling living area, so staff and the inspector respected their preference and did not disturb them.

In another house the residents welcomed the inspector into their home. The residents were supported by staff to engage in social distancing as much as possible and instead of shaking hands, residents bumped elbows with the inspector. The inspector observed there to be a lively and happy atmosphere in the house. One resident had just celebrated a milestone birthday that day and the excitement of the party was still in the atmosphere. One of the residents was engaged in an arts and craft project in the kitchen and another resident was working on a puzzle game in the sitting room. One resident showed the inspector a collection of their jigsaw puzzles which they enjoyed making. Other residents informed the inspector of the various video exercise classes they enjoyed and how they helped keep them fit and healthy. The inspector was informed that many of the residents enjoyed attending mass in the local church however, due to restrictions during the current health pandemic they could not attend in person. As an alternative, a video link to the mass was organised in the house every Sunday and the inspector was informed that residents enjoyed it so much, they now view a mass service every morning. Overall, residents were finding the current health pandemic restrictions difficult and in

particular the restrictions relating to visitors. In the interim, staff were supporting residents to engage with their families via video calls using their electronic hand-held devices.

Since the time spent communicating directly with residents on the day of the inspection was limited for infection prevention and control purposes, HIQA resident questionnaires were completed in advance. These questionnaires aimed to give residents an opportunity to provide feedback on what it is like to live in the centre. The inspectors reviewed a number of these questionnaires, which were completed. Feedback was positive overall, although the impact of the recent period of heightened public health restrictions around the time of the inspection was also apparent. Positive feedback was reported in relation to staff, meals, facilities, and respect for residents' rights. However, limited access to day services and community activities, such as swimming and going out for meals, as well as restrictions on visits to and from the centre, were noted in questionnaire responses to have negative impacts on the lived experiences of residents. While residents were supported by staff to take part in alternative activities in their homes, such as arts and crafts, baking and online exercise classes, residents still indicated that they preferred to have greater opportunities to participate in the community. However, staff reported that planning was underway to support residents to take part in further community activities in the weeks following the inspection, in line with planned reductions in public health restrictions.

Capacity and capability

This risk-based inspection took place to follow up on a recent thematic inspection which had been carried out in January 2020 which had raised some concerns regarding staffing levels and restrictive practice systems.

Overall, on the day of the inspection, the inspectors found that the registered provider and the person in charge were endeavouring to ensure that a quality service was provided to residents. The person in charge was knowledgeable about the support needs of the residents and this was demonstrated through the care and support provided to residents. There was a staff culture in place which promoted and protected the rights and dignity of residents through person-centred care and support. However, the inspectors found that a number of improvements were required, in particular, in relation to staff training, oversight of and review of documentation, positive behaviour support and the review and use of restrictive practices.

The inspectors found that governance and management systems in place included monthly meetings between the person in charge (via online video technology) during the current health pandemic with the director of operations, the person participating in management and persons in charge from other centres in the organisation. Organisational management matters relating to each of the

centres were discussed and shared, including updates regarding the current health pandemic. At each meeting, actions required and persons responsible, including time lines were identified and followed up at the next meeting.

Overall, the inspectors found that there was appropriate oversight of the day-to-day management of the centre and residents' care and support. The person in charge was involved in, and had oversight of, a schedule of local audits relating to residents' finances, care plans, and medication. Local audits were also being carried out in relation food and nutrition, health and safety and infection control.

However, regarding the oversight and review of documentation in the centre, a number of improvements were required. For example, the inspector found the systems in place to review residents' personal, health and behavioural support plans did not adequately assess the effectiveness of the plans. Furthermore, improvements to the oversight of the quarterly notifications was required as not all quarterly notifications in relation to the use of restrictive practices had been submitted in line with the time frames identified in the regulations.

The inspectors found that the annual review of the quality and safety of care and support in the designated had not been completed by the provider for 2019. A six-monthly visit had been carried out in November 2020 however, the review was not unannounced as per the regulatory requirement.

The inspectors found that for the most part, the education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice. The training needs of staff were regularly monitored and addressed to ensure the delivery of good quality, safe and effective services for the residents. The inspectors found that staff had been provided with mandatory training such as fire safety, manual handling and safeguarding however, not all refresher training in a number of these areas were up-to-date. The person in charge advised the inspector that they were carrying out one to one supervision and performance appraisal meetings with staff to support them perform their duties to the best of their ability. However, on the day of inspection not all staff had been provided with one to one supervision meetings in line with the centre's guidelines.

The inspectors spoke briefly with a small number of staff on the day of the inspection, and found them to have good knowledge of the residents and their individual needs and preferences. Staff were observed interacting with residents in a kind and respectful manner. There was one nursing staff vacancy on the day of inspection, and the person in charge outlined the arrangements that were in place to ensure that this vacancy did not impact on the availability of appropriate nursing care to the residents. The inspectors reviewed a sample of planned and actual staff rosters for the months prior to the inspection, and found that the number and skill mix of staff on duty in each house were in line with the centre’s statement of purpose and the assessed needs of the residents. Staff absences were found to be covered by members of the existing staff team in each house, for the most part, or occasionally by a small number of relief staff, which promoted continuity of care. Sample staff files viewed by the inspectors contained the required information and

documentation, with the exception of one file which was missing one piece of documentation.

Regulation 15: Staffing

The registered provider had ensured that an appropriate number of staff with the requisite skills to meet residents' assessed needs were available, and that continuity of care and support was provided. Planned and actual staff rosters were maintained by the person in charge. Of the sample staff files reviewed, one file was missing one piece of documentation that was required as per Schedule 2.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors found evidence that staff had received mandatory training however, not all refresher training was up-to-date. For example, not all staff had completed refresher training in fire safety, manual handling or food safety.

Staff who spoke with the inspector demonstrated good understanding of the resident's needs and were knowledgeable of the procedures which related to the general welfare and protection of residents.

Supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability however, not all staff had been provided with supervision in line with the centre's guidelines.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure was clearly defined and staff were aware of their responsibilities in relation to the management of the centre.

The inspectors found that the review and oversight of documentation in the centre required improvements. The systems in place to review residents' personal, health and behavioural support plans did not adequately assess the effectiveness of the plans.

Improvements to the oversight of the quarterly notifications was required as not all quarterly notifications in relation to the use of restrictive practices had been submitted in line with the time frames identified in the regulations.

An annual review of the quality and safety of care and support in the designated had not been completed by the provider for 2019. A six-monthly visit had been carried out in November 2020 however, it was not unannounced as per the regulatory requirement.

Judgment: Not compliant

Regulation 31: Notification of incidents

The Chief Inspector was not given written notice at the end of each quarter in relation to the use of restrictive practices in the centre. For example, not all quarterly notifications in relation to the use of restrictive practices had been submitted in line with the time frame identified in the regulations. In addition, a notification was incorrectly submitted to this centre which was regarding another centre and incorrect details, such as date and resident's identification number, had been included on a three-day notification..

Judgment: Not compliant

Regulation 4: Written policies and procedures

The inspectors found that not all Schedule 5 policies and procedures had been reviewed within the time frame required in the regulations, for example, the policy on incidents where a resident goes missing had not been reviewed since April 2017. On the day of inspection the policy on provision of behavioural support was not made available to the inspectors for review. In addition to the specified Schedule 5 policies, the registered provider’s infection control policy required revision in light of changes to relevant national standards and guidance that have been issued since the policy was last updated in August 2016.

Judgment: Substantially compliant

Quality and safety

The inspectors found that overall the residents' well-being and welfare was maintained to a good standard and that the person in charge and staff endeavoured

to promote a person-centred culture within the centre. Each house was well run and provided a pleasant environment for the residents. Overall, the person in charge and staff were aware of residents' needs and knowledgeable in the care practices to meet those needs. However, improvements were required in relation to residents' healthcare plans, positive behaviour support and to some of the restrictive practices systems in place in the centre.

The inspectors found that the centre strived to promote a positive approach in responding to behaviours that challenge. Where appropriate, residents were provided with positive behaviour support plans which, for the most part, included proactive and reactive strategies to guide and support staff manage behaviours that were challenging. There were also appropriate risk assessments in place for behaviours that challenge. There were guidelines for supporting people with behaviours of concern in place to guide staff in their practice which had been recently updated in November 2020.

However, on the day of inspection a number of improvements to the positive behaviour support systems in place in the centre were warranted. Although there were guidelines in place in the centre and were made available to the inspectors, on the day of inspection no policy on provision of behavioural support was made available to the inspectors.

On review of residents' positive behavioural support plans the inspectors found that overall, not all plans had been developed or reviewed by the appropriate multidisciplinary team member. Overall, the inspectors found that oversight and review of residents' positive behaviour support plans did not adequately assess the effectiveness of the plans. In addition, the inspectors found that not all staff had been provided with training in managing behaviour that is challenging, including escalation and intervention techniques.

There were a number of restrictive practices in place in the centre. There was a restrictive policy in place in the designated centre which was up-to-date and made available to staff. The inspectors found that the restrictive practices were supported by appropriate risk assessments which were reviewed on a regular basis. Risk assessments in place monitored and evaluated the risks and benefits of the restriction on residents' wellbeing and included the various control measures in place to reduce or mitigate the risk.

The inspectors saw that a review of each restrictive practice in place in the centre had been carried out (via video call) and included members of a multidisciplinary team, the service manager and the person participating in management. The review addressed the alternatives and trials that had been considered to lessen a number of restrictions in place. However, the inspectors saw that the review did not include the resident or where appropriate, their family member or representative. Overall, the inspectors found that there was insufficient documentary evidence to demonstrate that the use of an assisted decision-making process (as per the designated centre's guidelines) was included in the overall restrictive practice process.

The inspectors found that residents' personal plans were developed and reviewed with the participation of each resident, their family or representatives and in accordance with residents' wishes, age and the nature of their disability. Overall, residents' personal plans were person-centred and reflected the continued assessed needs of each resident and outlined the supports required in accordance with their individual needs and choices.

Multidisciplinary reviews of the personal plans involved assessing the effectiveness of the plan and took into account changes in residents' circumstances and new developments in their lives. Overall, residents' plans were being reviewed on an annual basis in consultation with the resident, relevant key worker and where appropriate, allied health professional and members of residents' family. The inspectors found that not all plans had included a multidisciplinary review in 2020 however, this was primarily due to restrictions and limitations surrounding the current health pandemic. This had been acknowledge at senior management level and plans were in place to commence the multidisciplinary reviews in 2021.

Residents were provided with their own accessible format of their personal plan which overall, were reviewed regularly and were up-to-date. Each resident's plan included information on people who were important to them, what they enjoyed talking about, what their food and beverage preferences were and aspects of their life that represented their identity.

From a sample of residents' healthcare plans, the inspectors found that each resident had access to allied health professionals including access to their general practitioner (GP). There were local guidelines in place for accessing residents' GP, consultants, out-of-hours doctor service (D-DOC) and various other allied health professionals during the COVID-19 health pandemic.

Each resident's healthcare plan included a health profile of the resident and a variety of health action plans. The health action plans included a comprehensive assessment of the residents' health needs and identified supports required to meet those needs. However, the inspector found that the reviews of the plans were did not adequately assess the effectiveness of the plans. For example, some plans included a date at the bottom of the plan to signify it had been reviewed however, in many cases there was no comment, signature or name of the person who reviewed the plan. A number of plans included a review date of 2020 however, the previous date of review was in 2018.

There was evidence to show that residents were consulted regarding their health. Residents were supported to access health information including health matters relating to COVID-19. For example, there was a variety of easy-to-read guides available to residents so that they could better understand different aspects of their health and how to live a healthy life. Residents were provided with a hospital passport to support them if they needed to receive care or undergo treatment in the hospital.

The inspectors found that where appropriate, and in line with residents wishes, residents were facilitated to access the flu vaccination and many residents had been

facilitated to access appropriate health screening. However, overall, the inspectors found that where residents had refused screening programmes, the follow-up required review to ensure every effort had been made to include the resident in the decision-making process.

There was an up-to-date safeguarding policy in place in the centre which was made available to staff. Staff had been provided with the appropriate training in safeguarding. The inspectors found that staff facilitated a supportive environment which enabled the residents to feel safe and protected from abuse. The inspectors saw that staff treated residents with respect and that personal care practices regarded residents' privacy and dignity. The culture in the house espoused one of openness and transparency where residents could raise and discuss any issues without prejudice. Overall, the inspectors found that the residents were protected by practices that promoted their safety.

There were systems in place to ensure that residents were consulted with and participated in the running of the centre. Inspectors saw evidence that two residents living in the centre were involved in the registered provider's resident advocacy group, where they acted as representatives for their peers. Within the centre, monthly residents' meetings took place in each house, and records reviewed by inspectors showed that these meetings provided a forum for all residents to discuss matters of importance to them in their daily lives. There was also evidence that these meetings gave residents the opportunity to effect changes in the centre, for example, where a maintenance issue was raised by a resident, staff logged the issue and ensured it was addressed. Residents also had opportunities to learn about and discuss COVID-19 and its implications for them at residents' meetings. In addition, the provider had prepared easy-to-read information for residents in relation to COVID-19, including materials to support residents to make informed decisions around consent to testing and treatment, and to support residents to understand when, why and how they may experience rights restrictions for public health purposes.

On the day of inspection, the premises were found to be clean, in good repair, suitably decorated and were designed and laid out to meet the numbers and needs of residents. All residents had their own bedrooms and there was adequate communal space in each house for social activities, recreation and dining. There were separate large, accessible bath and shower rooms which were appropriate to residents' mobility needs. Suitable laundry, storage and waste disposal facilities were also in place in each house. To the rear of each house was a patio area with picnic benches. There was a large communal outdoor area to the rear of all houses that was well maintained and, on the day of the inspection, was decorated with lighting and other seasonal decorations.

The registered provider had ensured that there were systems in place in the centre for the assessment, management and ongoing review of risk. The provider's risk management policy was up-to-date and contained all information required by the regulations. Risk registers were in place for each house in the centre. A sample risk register was reviewed by the inspectors and was found to clearly identify the relevant risks in that house, in line with the assessed needs of the residents,

including risks related to COVID-19. Details of the assessment of each risk and the control measures in place to mitigate it were clearly outlined. The inspectors also saw written evidence that any incidents and accidents that took place in the centre were appropriately recorded, and such occurrences were reviewed periodically in order to learn from them.

The registered provider had effective systems in place to prevent and control the potential spread of COVID-19 in the centre. There were no suspected or confirmed cases of COVID-19 in the centre at the time of the inspection, and although previous isolated cases had arisen among staff, there was no evidence of transmission of infection within the centre, and residents were adequately protected from infection. The registered provider had an up-to-date COVID-19 response plan and business continuity plan, which included comprehensive guidance on infection prevention and control measures, the management of suspected or confirmed cases of COVID-19 among residents and staff, and contingency plans in relation to staffing and other essential services such as laundry, catering and waste management. However, the provider's general infection control policy had not been updated in a number of years, and contained information that required revision in light of updated national standards and guidance. The provider had ensured that residents in the centre had access to alternative accommodation should they be required to self-isolate due to COVID-19 and be unable to do so in their homes. The areas of the centre observed by the inspectors were visibly clean, and records indicated that regular cleaning of the centre was taking place. Records indicated that staff were provided with training in hand hygiene and the use of personal protective equipment (PPE). Hand sanitiser and hand soap were available in appropriate areas throughout the centre, and staff were observed wearing disposable surgical masks, in line with current guidance. Records indicated that adequate supplies of PPE were available in the centre, and the registered provider had additional stores to be made available as required. Risk assessments and guidelines in relation to visitors to the centre had been updated in line with the most recently-published guidance from the Health Protection Surveillance Centre. Arrangements for outdoor visits were in place, and to facilitate such visits in times of poor weather, the provider had erected a gazebo in a communal outdoor area.

The registered provider had ensured that there were fire safety management systems in place in the centre, and clear arrangements were in place in case of fire. Residents had Personal Emergency Evacuation Plans (PEEPs), which included guidance for staff on the supports each resident required to evacuate by day and by night. However, some residents' PEEPs required review to ensure that they included sufficient detail on the resident's current requirements for support, particularly in relation to mobility and transfers. Sample records of fire drills that had taken place over the past 18 months indicated that drills had been carried out at varying times of day and with varying numbers of staff present, some of which were designed to replicate night-time evacuation procedures. Improvements were required to some documentation to ensure that the residents who participated, the outcomes and any recommendations arising were clearly and consistently recorded for all fire drills.

Regulation 26: Risk management procedures

The registered provider had systems in place in the centre to ensure that risks were assessed, managed and reviewed on an ongoing basis. A sample risk register reviewed was found to adequately outline all relevant current risks and related control measures, in line with residents' assessed needs, including risks related to COVID-19.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had effective systems in place to prevent and control the potential spread of COVID-19 in the centre, and adequate contingency arrangements in case of infection. The centre was visibly clean and staff were observed adhering to infection prevention and control practices. Updated guidelines and risk assessments in relation to visitors to the centre were also in place, and were in line with the most recently-published guidance from the Health Protection Surveillance Centre at the time of the inspection.

Judgment: Compliant

Regulation 28: Fire precautions

Some residents' Personal Emergency Evacuation Plans required review to ensure that they adequately guided staff on the resident's current requirements for support, particularly in relation to mobility and transfers. Documentation of fire drills required some improvements to ensure that the residents who participated, the outcomes of the drill and any recommendations arising were clearly and consistently recorded.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident was provided with a personal plan and included an assessment of need and the supports required to meet those needs. Residents were provided with an easy-to-read version of their plan and for the most part, these plans were reviewed in consultation with the residents and were up-to-date.

Judgment: Compliant

Regulation 6: Health care

Residents had their healthcare needs assessed and care plans developed in line with their needs. Residents were provided with health action plans which included a comprehensive assessment of their healthcare needs and identified supports required to meet those needs. However, the inspectors found that the reviews of the plans were did not adequately assess the effectiveness of the plans. For example, some plans included a date at the bottom of the plan to signify it had been reviewed however, in many cases there was no comment, signature or name of the person who reviewed the plan. A number of plans included a review date of 2020 however, the previous date of review was in 2018.

Overall residents were facilitated to access appropriate health screening. However, the inspectors found that where residents had refused screening programmes, the follow-up required review to ensure every effort had been made to include the resident in the decision-making process.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There was no policy on provision of behavioural support made available to the inspectors on the day of inspection.

Not all residents' behaviour support plans, had been developed or reviewed by an appropriate multidisciplinary team member.

Not all staff were provided with the appropriate training in the management of behaviours that is challenging including, de-escalation and intervention techniques.

There was insufficient documentary evidence to demonstrate that the use of an assisted decision-making process (as per the designated centre's guidelines) was included in the restrictive practice process.

Judgment: Not compliant

Regulation 8: Protection

There was an up-to-date policy on safeguarding in place in the designated centre which was made available to staff. There was an atmosphere of friendliness, and the residents' modesty and privacy was observed to be respected. The residents were protected by practices that promoted their safety; residents' intimate care plans ensured that the resident's dignity, safety and welfare was guaranteed.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted with and participated in the running of the centre. The registered provider had prepared accessible materials to support residents to learn about COVID-19, to understand the impacts of public health measures on their rights, and to support informed decision-making and consent in relation testing and treatment.

Matters relating to the resident's rights regarding assisted decision-making have been dealt with in Regulations 6 and 7.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Glen 2 OSV-0001439

Inspection ID: MON-0025733

Date of inspection: 03/12/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• The person in charge will ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

• Currently 11 staff are due refresher in Food safety and the PIC has linked with the education department who have secured a contract with the Food Safety Co. Places will be allocated to these priority staff as the training becomes available

• Currently 6 staff are due refresher in Fire Safety and the PIC has scheduled these to be completed . The training department has assured the PIC that there will be a monthly allocation of places on fire training secured to the designated Centre

• Manual Handling - 4 staff are due refreshers and the PIC will schedule staff to complete this training .

• The PIC is linking with the training department to secure staff with places on Managing Challenging Behaviour courses which have recently returned for face to face. A priority list is in place but due to covid-19 and the changing levels of restrictions this may impact on the delivery of training

• The PIC will provide oversight to ensure all staff update mandatory training on HSEland.

• PIC has linked with CNS in behaviour to arange Zoom workshops in relation to Behaviours of Concern and Positive Behaviour Support Plans.

• The PIC shall ensure that staff are appropriately supervised. Supervision and performancece Decelopement review schedule is in place and has commenced.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
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.
• Quality and Risk officer has been appointed and in place since August 2020
• The PIC has been in contact with Quality and Risk Officer and work has commenced on the Annual Review Report and will be completed by the end of February 2021.
• The PIC/PPIM will ensure there is oversight of documentation. Incidents are reviewed as occur and then reviewed quarterly. The PIC/PPIM will share the findings of these reviews with staff teams during monthly team meetings, audits and supervision.
• An Audit schedule is in place to review documentation and the actions are added to the Quality Enhancement Action Plan(QEAP) .
• The Register Provider will carry out unannounced audits throughout the year within designated center. Guidance in place on how provide oversight/audits during the covid-19 pandemic

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC/PPIM will ensure that notifications are sent in to the Chief Inspector within the timeframes set out in the regulations and a more robust system of oversight has been established and any future absences will not impact on the punctuality of the notifications going forward
• The PIC will review quarterly RP's in the designated center and return these in a timely manner as per regulation
• All notifications will be checked by the PIC before submitting to HIQA

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• A number of policies had been updated included the missing persons policy updated last on the 27.11.20

• All polices up to date are available in soft copy on the public folder and all Schedule 5 are updated and are located in hard copy within the designated centre.
• The Infection control policy was updated in April 2020 in line with National standards and this is in situ in the designated centre and the PIC/PPIM will ensure that all staff are familiar with any updates

Update from provider
o – 15/01/2021 Infection Control Policy was submitted to HIQA
o – 20/01/2021 Positive Behavioural support guidelines will be changed to Provision of Behavioural support policy.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC will ensure all documentation for fire drills will be recorded to ensure that residents who participated and the outcomes and that the actions will be clearly and consistency recorded on the fire drill record sheet

• Health & Safety Meeting have been scheduled for the year and the Health and Safety reps attend where Fire Evacuation is an agenda item at these meetings.

• The registered provider will ensure the PIC plans and organises fire drills at suitable intervals, that staff and, in so far as are reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

• The PIC will ensure all the PEEP's will reviewed and updated(immediate action) for each resident to ensure that they adequately guided staff on the resident's current requirements for support, particularly in relation to mobility and transfers.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The PIC will ensure that residents are supported with assisted decision making about their health care treatment and screening through accessible information such as easy to read documents
• The PIC shall ensure that the resident's right to refuse medical treatment shall be respected. Such refusal shall be documented and the matter brought to the attention of the resident's medical practitioner. Alternative measures will be discussed and offered to the resident. Support from the Multidisciplinary team will be sought for advice if need.

• Health care Treatment and Screening will be discussed at yearly MDTs which the resident and family are invited to attend
• The PIC will maintain a screening tool of the National Screening Programme available to each resident.
• The PIC will ensure that care plans are reviewed as per schedule already distributed to the centre for 2021 with staff appointed to assess the quality of the reviews quarterly
• The plans and interventions will be evaluated reflecting the on going needs changing needs of the resident

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The person in charge shall 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.

• Person in charge will link with CNS in behaviour to arrange a schedule for bespoke training to support individuals with behaviours of concern such as workshops in the bungalows with staff including; de-escalation and intervention techniques.

• 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. The PIC will oversee a restraint reduction strategy within the designated centre

• In order to demostrate that an assisted decision making process was included in the restrictive practice process; more accessible information will be made available to the resident in the form of easy read and video format. Support will be given to resident to understand this and reduction plans and be part of process. This will be documented. Key support persons have always been informed of the restrictions in place and this will continue in letter format; copy to care plan and any feedback shared with team. Residents and Families are invited to attend yeary MDT meetings and restrictions are reviewed annually .

Update from Provider – – 20/01/2021 Positive Behavioural support guidelines will be changed to Provision of Behavioural support 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 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	31/03/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2021
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	Substantially Compliant	Yellow	01/03/2021

	and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	28/02/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall 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 shall 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.	Substantially Compliant	Yellow	31/01/2021
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the	Substantially Compliant	Yellow	31/03/2021

	workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/12/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/12/2020
Regulation 31(1)(b)	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: an outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre.	Substantially Compliant	Yellow	04/12/2020

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.	Substantially Compliant	Yellow	04/12/2020
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	04/12/2021
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	16/02/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in	Substantially Compliant	Yellow	16/02/2021

	paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/12/2021
Regulation 06(2)(c)	The person in charge shall ensure that the resident's right to refuse medical treatment shall be respected. Such refusal shall be documented and the matter brought to the attention of the resident's medical practitioner.	Substantially Compliant	Yellow	03/06/2021
Regulation 07(1)	The person in charge shall 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.	Substantially Compliant	Yellow	30/06/2021
Regulation 07(2)	The person in charge shall	Not Compliant	Orange	30/06/2021

	ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.			
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.	Not Compliant	Orange	30/06/2021