Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Glen 3
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	19 November 2020
Centre ID:	OSV-0003727
Fieldwork ID:	MON-0028130

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. 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:	15

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 19 November 2020	10:30hrs to 17:00hrs	Marie Byrne	Lead
Thursday 19 November 2020	10:30hrs to 17:00hrs	Jacqueline Joynt	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet and briefly engage with 12 residents during the inspection. As the inspection was completed during the COVID-19 pandemic, the inspectors adhered to national best practice and guidance with respect to infection prevention and control. The inspectors reviewed documentation in an office location and visited one house each and the back garden of the third house, over the course of the inspection.

There were 15 residents living in the designated centre at the time of the inspection, all of whom were women. In addition to meeting 12 residents, each of the 15 residents, completed or was supported by staff to complete a questionnaire for residents prior to the inspection.

In one of the houses, 3 residents were relaxing in the living room areas prior to having their evening meal. The other two residents who lived in this house had just gone out with staff for a bus drive locally. The three residents who were at home did not engage verbally with the inspector, but they all appeared comfortable and content.

The inspector was met with the pleasant smell of evening tea coming from the oven, as they walked in the front door. There was a menu available for the week which had been discussed at the latest residents' meeting, and an accessible version of the options for each day was made available for residents prior to and during mealtimes. Hot meals were provided from the central kitchen on the campus, but there were also facilities in each of the houses to cook and bake. There were plenty of options for snacks and drinks in the food presses and the fridge.

The house was warm and there was a relaxed atmosphere. The two staff who spoke with the inspector were very familiar with the residents' likes and dislikes and talked about things they liked to do during the day. They spoke about how choices were presented to residents in relation to their meals and snacks and how they wished to spend their time. They also talked about the impact for residents of visiting restrictions in line with the current level of government restrictions during the pandemic and talked about how they were supporting them to stay in contact with their loved ones. They described how much residents loved Christmas and told the inspector about how important it would be for them to have a special and enjoyable Christmas this year.

The inspectors visited the back garden of one of the houses and briefly spoke to three residents living there. They all greeted the inspectors and appeared comfortable and content in their home. One resident had been expecting a visit from the inspectors and showed them a document which staff had given them to explain the inspection process.

In another house, five residents were living in the main section of the house and

one resident was provided a single living arrangement which was part of the overall house. The inspector was provided with the opportunity to meet and speak with all six residents. Most of the residents used non-verbal communication and where appropriate, staff supported conversations and engagements between the inspector and the residents.

The inspector met with a resident who was residing in the single living arrangement section of the house. On greeting the inspector the resident indicated that they would like to go for a walk outside. A staff member was made available immediately to support the resident's wishes. The inspector observed kind and caring interactions between the staff and the resident when supporting them put on the appropriate outdoor clothing and in supporting them interact with the inspector.

In the main living area of the house the inspector observed four of the residents completing an art and craft project. Residents had decorated cards which included names of their friends and family members who had passed. The inspector was advised that the cards were for the centre's outdoor memorial service the following day.

The inspector observed that the atmosphere in the main living area was lively and busy, and interactions between the residents was quite loud at times. Not all residents chose to engage in this activity and where this was the case, they were supported to sit away from the group and listen to relaxing music.

In a number of the questionnaires, it identified that residents had been living in the centre since it opened 13 years ago. Overall, the questionnaires indicated that residents were happy living in the designated centre. Most of the questionnaires indicated that residents were happy with how comfortable the centre is, how warm it is, their access to shared areas and to their garden.

They questionnaires also indicated that residents were happy with the food, mealtimes, cooking and dining facilities. A number of residents described their favourite foods and how they liked it presented. Overall, residents were satisfied with arrangements for visitors and how welcome staff made their visitors feel. However, in line with the current level of government restrictions in line with the COVID-19 pandemic, a number of residents indicated they were not having visitors and indicated they were looking forward to this changing.

Each questionnaire indicated that residents were happy with their choices, privacy and how safe they felt in the centre. Two residents' questionnaires indicated they were happy when they saw familiar staff working with them. Most of the questionnaires indicated that residents were happy with the support they received from staff to achieve their goals. One residents' questionnaire indicted that the resident was happy with how staff supported them and described the centre as ''good''. Another resident described the centre as calm and peaceful.

In each questionnaire there was a list of activities residents enjoy in the centre, and outside of the centre. The activities listed in the centre included; arts and crafts, listening to music, motor skills activities, baking, making video calls, having a foot spa, visiting the sensory garden, doing puzzles, gardening, having meals with

friends, or doing chair exercises. Those listed for outside the centre included going; shopping, to mass, to the cinema, to the hairdressers, to the theatre, for bus drives, for walks in the local park, and going for picnics in the local park. They also included, visiting the dogs trust, dining out, attending a local community woman's group, going to bingo, and attending choir.

Each questionnaire indicated that residents were aware of the complaints process and would talk to the staff or the management team if they were unhappy with anything. One resident described their experience of the complaints process in the designated centre. They stated they were happy with the way the complaint was dealt with, how quickly it was dealt with, and with the response provided to them following the complaint.

A number of residents' questionnaires indicated that there were some areas where they would like to see improvements. A number of these related to their access to activities including community based activities. For example, one resident who likes going to mass in the local community would like to have the opportunity to attend every week. Another resident who is a wheelchair user and requires the use of the bus to access their local community, indicated that not all staff are drivers and that its difficult to access their local community at times.

One residents' questionnaire indicated that they would like new blinds for their sitting room and a proper signal on their television so it could connect to video calls better. They were currently viewing them on a mobile phone. The provider was working with an external company to improve the signal at the time of the inspection.

A residents' questionnaire also indicated that they had been waiting to have their sitting room painted since the beginning of the COVID-19 pandemic, and that they would like to go shopping to the local supermarket to choose more options for their supper. Another residents' questionnaire indicated they would like their surroundings to be more adapted to suit their needs and that they needed more sensory items.

One residents' questionnaire indicated that they were completing activities in their home including activities via video call. However, it also indicated that they had not accessed activities outside of the centre since the beginning of March 2020. Another residents' questionnaire stated that they just couldn't wait to get back out into the community.

Capacity and capability

The registered provider was striving to ensure that residents were in receipt of a good quality and safe service. They had systems in place to monitor the quality of care and support for residents. However, they were not fully implementing these systems at the time of the inspection. There was evidence that improvements had

been made in the centre since the last inspection in relation to the premises, residents rights, and staffing. However, improvements were still required in relation to staff training, oversight of and review of documentation, positive behaviour support, the review and use of restrictive practices, and residents' access to meaningful activities and to their local community.

This risk based inspection was completed in response to information of concern received by the Chief Inspector in the form of unsolicited information. The inspection was also completed to review building works following an application to remove and additional restrictive condition of registration for the centre relating to building works in one of the houses in the designated centre.

The person in charge had been on unplanned leave since May 2020. In their absence, the person participating in the management of the designated centre (PPIM) and service manager were supporting the staff team. A notification had been submitted to the Chief Inspector to identify the PPIM as the person responsible during their absence. In addition, a clinical nurse manager had recently been facilitated to take a more active role in the day-to-day management of the centre. The inspectors were informed during the inspection that the person in charge would not be returning to the centre, and that the provider was in the process of recruiting to fill this post. The PPIM facilitated this inspection, they had previously been person in charge in this centre and were familiar with residents' care and support needs and with their responsibilities in relation to the regulations.

There was evidence of oversight in relation to the day-to-day management of the centre and residents' care and support. However, there were a number of areas where improvements was required in relation to the oversight and review of documentation in the centre. For example, accident and incident reviews were being completed but there was no evidence that the person in charge/person participating in the management of the designated centre had reviewed the findings, or that the learning following these reviews had been shared across the team. Improvement was also required in relation to the oversight and review of some residents' documentation such as personal plans, the review of restrictive practices, and positive behaviour support plans. In addition, the Chief Inspector was not given written notice at the end of each quarter in 2020 in relation to the use of restrictive practices, and a number of notifications were not submitted in line with the timeframes identified in the regulations. In addition, a number of notifications were submitted for this centre which related to other designated centres.

The provider had not completed an annual review in the centre in 2019. There was evidence that the service manager and PPIM had escalated this to the provider. The provider had recruited to fill a vacancy for a quality and risk officer and plans were in place to complete an annual review for 2020. Two six monthly visits by the provider had been completed in 2020 and the findings were similar to those of this inspection. These had not been completed within the timeframes identified in the regulations, but in the interim the service manager and PPIM were linking with residents and staff regularly. Actions were identified following the last two six monthly reviews and there was evidence that a number of these actions were

progressing in line with the timeframes identified by the provider.

Improvements were noted in relation to staffing numbers and continuity of care and support for residents since the last inspection. There were a number of vacancies in the centre at the time of the inspection including, two staff nurse vacancies, a care staff vacancy and 0.5 social care worker. While recruiting to fill these positions, the provider was covering all of the required shifts through the use of regular relief staff and the redeployment of a staff nurse from another area. They had recently become aware of the person in charge vacancy and plans were in place to recruit to fill this post. Planned and actual rosters were in place in the centre. However, from reviewing a sample of rosters, they were not always well maintained. For example, from reviewing a number of rosters for one house it appeared that a number of shifts had not been covered and that the area was short staffed on these occasions. However, the inspectors were shown documentary evidence during the inspection that all of these shifts were covered. In addition, the second name of staff were not always included on the actual rosters.

Staff had access to training in line with the organisation's policies. They had also completed additional training in line with residents' needs. However, a number of staff required some training or refresher training. For example, a number of staff were due refresher training in fire safety awareness, manual handling and food safety training. In addition, a number of staff required training in managing behaviour that is challenging. In relation to fire safety training, staff were taking part in regular fire drills and plans were in place to prioritise this training after the inspection. The inspectors acknowledge that attempts had been made to access some online training during the pandemic and that staff had completed additional areas specific training in relation to infection prevention and control including handwashing and the use of personal protective equipment (PPE).

Formal staff supervision had commenced in the centre and plans were in place to ensure each staff member had an opportunity to take part in supervision in 2020. From the sample reviewed, it was evident that staff were being supported and their roles and responsibilities were being discussed along with their training needs.

There were admissions policies and procedures in the centre, and these were also outlined in the centre's statement of purpose. Perspective residents and their representatives were provided with an opportunity to visit the centre. Contracts of care were in place which contained the information required by the regulations. They outlined care and support and services to be provided for residents in the centre. They also outlined fees to be charged in line with residents' financial assessments and other fees which residents may be responsible for such as attending the hairdresser or other therapies such as massage or beauty therapy. These sample additional fees were detailed in the contract of care and sample costs included beside them as a guide. However, from reviewing a sample of residents' finances residents were not spending that much on these services.

There was a complaints policy in place and the complaints process was available and on display in an accessible format. There was a local complaints officer and systems in place to record, investigate, follow up on and document complaints. There was a

system in place to record complaints, to investigate them, to inform the complainant of the outcome, to record measures for improvement or actions taken as a result of the complaint, and a system to record the satisfaction level of the complainant. The complaints process involved a number of stages, clear timeframes for following up and responding to the complainant and there was an appeals process. A complaints log was maintained in the centre. There had been one documented complaint in the centre in 2020 and there was evidence that it was recorded and followed up on in line with the organisation's policies and procedures.

Regulation 15: Staffing

There were a number of staffing vacancies in the centre. The provider was in the process of recruiting to fill these, and in the interim they were filling the required shifts and ensuring continuity of care for residents through the use of regular relief and agency staff.

There were planned and actual rosters in place. However, improvements were required in relation to the maintenance of actual rosters. It was not clear from reviewing the rosters that every shift was covered. For example, for a large number of shifts it appeared as if there were insufficient staff on duty to meet the assessed needs of residents. The inspectors were shown documentary evidence during the inspection that all of these shifts were fully covered.

In addition, it was not clear on the roster which staff were regular or relief staff, and their second names were not always included on the roster.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to training and refresher training in line with residents' assessed needs. For example 100% of staff had completed safeguarding training and hand hygiene training. However, a number of staff had not completed some mandatory or refresher training programmes. For example;

- 10 staff were due refresher training in fire safety awareness,

- 1 staff was due refresher manual handling training

- 14 staff were due refresher food safety training.

In addition, a number of staff required training in managing behaviour that is challenging.

The inspectors were shown evidence that all staff who required it, were booked onto fire safety awareness following the inspection.

Formal staff supervision had commenced in the centre and there was a supervision plan in place to ensure each staff member was in receipt of supervision before the end of the year.

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. There were management systems to ensure that services provided were safe, appropriate to meet the needs of residents, consistent and effectively monitored. However, improvements were required in relation to the oversight and review of some documentation in the centre.

An annual review had not been completed by the provider for 2019. Six monthly unannounced visit were being completed and the findings were similar to those of this inspection. There was evidence that the actions from these reviews were progressing and leading to positive outcomes for residents in relation to their home and their care and support.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There were admissions policies and procedures in place. These procedures considered the wishes, needs and safety of other residents already residing in the centre.

The inspectors reviewed a sample of residents' contracts of care and found that they contained the information required by the Regulation. They detailed the services provided for residents, and the fees to be charged. They also included details of other charges for additional services residents were responsible for, which were not covered in the contract.

Judgment: 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, they had not been submitted at the end of quarter 1 in 2020. In addition, another notification had not been completed in line with the timeframe identified in the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The were complaints policies and procedures in place and they were available in an accessible format and on display in the centre.

Complaints were discussed during keyworker sessions and at residents' meetings.

There was one recorded formal complaint in the designated centre for 2020 and evidence that it had been recorded and followed up on in line with the organisations' policy.

Judgment: Compliant

Quality and safety

The provider and person in charge were striving to ensure that residents were in receipt of a good quality and safe service. They lived in a clean, warm and comfortable home. Most residents had lived in the centre since it opened and appeared happy and content in their home. However, improvements were required in relation to residents' access to meaningful activities and their community, positive behaviour support, the use and review of restrictive practices in the centre.

Overall, the centre endeavoured 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.

However, on the day of inspection a number of improvements to the positive behaviour support systems in place in the centre were warranted. There was evidence based guidelines on supporting persons with behaviours of concern in place in the centre which was made available to staff however, the document had not been updated since September 2017.

The guidelines advised that a behaviours of concern monitoring group, which

included relevant multidisciplinary members, met on a quarterly basis to monitor and evaluate training and education, incidents and accidents, behaviours of concern, restrictive practices (including audits) and positive behaviour support strategies. However, on the day of inspection there was no documentary evidence made available to the inspectors to demonstrate that the quarterly reviews were taking place.

There was a significant increase of non-serious injuries submitted to HIQA in the third quarter of this year. The provider had made efforts to identify and alleviate the cause of the increase. Positive behaviour support plans were in place which included guidance and information to support staff respond to residents' assessed support needs. A review was held in July 2020 and a referral to a member of the multidisciplinary team resulted in an environmental assessment. A number of the actions from the assessment were currently being trailed in the centre in an effort to reduce the number of incidents occurring. However, the inspector found that overall, not all positive behaviour support plans provided to residents, had been developed or reviewed by the appropriate multidisciplinary team member.

The accessibility of the positive behaviour support plans required reviewing to ensure that staff were able to effectively and efficiently source the required information when needed. For example, in one resident's personal plan, the inspectors found a number of positive behaviour support plans relating to different behaviours in various sections throughout the resident's plan.

On speaking with staff, the inspectors found that overall, they were knowledgeable on how to support residents manage their behaviours however, not all staff had been provided with training in managing behaviours that is challenging including escalation and intervention techniques.

There were a number of restrictive practices in place in the centre. 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 found that there had been a reduction of restrictive practices in the centre since the last inspection in 2019. Due to the completion of building works in one of the houses, previous limited access to bathroom and kitchen facilities had improved resulting in better outcomes for a resident. The single living arrangement apartment now included a new en-suite bathroom, living room with kitchenette. Access to the kitchenette and the rest of the house was still limited for the resident however, a number of alternatives had been trialled and continuous efforts to achieve the least restrictive alternative was ongoing. The inspectors were advised that a review meeting, specific to the restrictive practice in place for this resident, had been arranged for early December 2020.

There was a system in place to regularly review all the restrictive practices in the designated centre however, overall, the inspectors found that improvements were warranted to ensure that evidence of all alternative measures considered were

documented in the review to clearly demonstrate that, at all times, the least restrictive procedure for the shortest duration was used.

There was a restrictive policy in place in the designated centre which was up-to-date and made available to staff. The policy stated that in situations of limited capacity, the use of an assisted decision making process should be explored. However, on the day of inspection, there was no documentary evidence provided to the inspectors to clearly demonstrate that this process 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 and with their consent, 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 in to account changes in residents' circumstances and new developments in their lives. Residents' personal plans documented the progress and achievement of residents' goals through a monthly tracking system. Overall, residents plans were being reviewed on an annual basis in consultation with the resident, relevant keyworker and where appropriate, allied health professional and members of residents' family.

Residents were provided with their own assessable format of their personal plan. 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. Of the sample of plans reviewed by the inspectors, there were numerous photographs of residents enjoying various activities with friends, family and staff members. Residents enjoyed going for drives in the bus, going for walks in local parks, sensory activities such as head and hand massages, having a sensory bath, watching television and listening to music.

Overall, appropriate healthcare was made available to residents having regard to their personal plan. The health and wellbeing of each resident was promoted and supported in a variety of ways including through diet, nutrition, recreation, exercise and physical activities. The inspectors found that the residents were supported to live healthily.

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 resident's health needs and identified supports required to meet

those needs. The health action plans were reflective in nature, incorporating a section for evaluation to ensure that there was an appropriate and timely review of the plans.

There was evidence to show that residents were consulted regarding their health. Residents were supported to access health information. 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.

Resident's healthcare plans had been updated to include matters relating to the current health pandemic. Where appropriate, residents were supported through easy-to-read information on COVID-19 swab testing included what the procedure entailed, receipt and meaning of different test results and support provided by staff.

The inspectors found that where appropriate, and in line with residents wishes, residents were facilitated to access the flu vaccination. The provider was in the process of developing an adequate system to ensure that, where residents were facilitated to access national screening programmes, that the system incorporated an appropriate decision making process for the residents.

The inspector found that, overall, residents were protected by practices that promoted their safety. Staff facilitated a supportive environment which enabled the residents to feel safe and protected from abuse. Staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. There was an up-to-date safeguarding policy in place and made available to staff. Easy-to-read information relating to safeguarding matters was made available to residents. Overall, incidents, allegations and suspicions of abuse at the centre were investigated in accordance with the centre's policy. Appropriate safeguarding measures had been put in place to ensure that staff providing personal intimate care to residents, who required such assistance, did so in line with each resident's personal plan and in a manner that respected each resident's dignity and bodily integrity.

The inspectors found that residents were supported to maintain relationships with their friends and family. Staff supported residents to keep in contact with family members during the current health pandemic through telephone calls, cards and video calls. On the day of inspection, the residents were being supported to remember friends and family who had died. Residents had made decorative cards to bring to an outdoor memorial service taking place in the grounds of the centre the following day.

Residents were provided with activity records where they could choose from a list of different activities which they enjoyed. The inspectors saw that, during a period where self-isolation was required, a resident was provided with a specific two week activity record to support them keep active during this time. The activities included video exercise classes, hand massages, chair exercise and Karioke.

The inspectors found that overall, residents were engaging in a range of social and personal activities which they enjoyed however, to fully promote the general welfare and development of residents, improvements were required to the range of activities to ensure they incorporated occupational and educational opportunities suited to residents' personal aptitude and interests.

The inspectors observed that overall, the centre was promoting the rights of residents and this was highlighted through residents' house meetings which included matters such as making a complaint, safeguarding and advocacy information on the agenda. Furthermore, the residents were supported to understand their right to make a complaint and to avail of advocacy services through easy-to-read information made available to them.

The inspectors observed that residents had been advised of the inspection and were provided with easy-to-read social stories informing them of the purpose of the inspection and what to expect when the inspectors visited their house. Residents were informed and made aware that the inspectors would be wearing a face mask and practicing social distancing while in their home.

The residents had been supported to voice their opinions regarding the service and supports they received through completing HIQA questionnaires in advance of the inspection. The residents were kept up to date and aware of the current health pandemic through conversations with staff, house meetings and a variety of easy-to-read booklets. The residents were also provided with social stories about keeping safe during COVID-19, level 5 restrictions, hand hygiene practices and changes to visitor guidelines.

Changes had occurred in the centre since the last inspection, which had resulted in the centre appearing more comfortable and homely. It had also resulted in one resident now having additional private and communal space available to them. Building works had been fully completed since the last inspection. The centre was clean and areas in need of repair, maintenance or decoration were recorded and sent to the maintenance department. There was suitable heating, lighting and ventilation in place.

Residents were protected by the risk management polices, procedures and practices in the centre. There was a risk register which was regularly reviewed and updated. General and individual risk assessments were developed and reviewed as required. There were systems in place for responding to emergencies and for recording, investigating and learning from serious incidents and adverse events.

During the inspection, the premises was found to be clean. There were cleaning schedules in place, which had been adapted in line with COVID-19. Information was available for residents and staff in relation to COVID-19 and infection prevention and control. The provider had developed or updated existing policies, procedures relating to infection prevention and control. They had also developed contingency plans for use during the pandemic. There were systems to ensure there were adequate supplies of PPE at all times. Staff had completed training in infection prevention and control and the use of PPE.

Regulation 12: Personal possessions

Residents had access to and were supported to retain control over their personal property.

Resident were supported to manage their finances. From the sample of residents' financial transactions reviewed, there was evidence that there were receipts in place for all purchases, and purchases were in line with their identified likes and preferences. For example, one resident who liked puzzles had purchased a number of these and another resident who liked arts and crafts was purchasing items relating to arts and crafts regularly.

A number of residents did not have an account in their name in a financial institution. The provider was working with a number of financial institutions to support residents to open their own accounts. In the interim, there were systems in place to ensure residents could access their money and systems to ensure their income and expenditure were tracked and audited.

Judgment: Compliant

Regulation 13: General welfare and development

The inspectors found that overall, residents were engaging in a range of social and personal activities which they enjoyed however, to fully promote the general welfare and development of residents, improvements were required to the range of activities to ensure they incorporated occupational and educational opportunities suited to residents' personal aptitude and interests.

Judgment: Substantially compliant

Regulation 17: Premises

The premises visited were clean, warm, comfortable and homely. They were well maintained internally and externally and designed and laid out to meet the number and needs of residents in the centre.

Building works had been completed since the last inspection to ensure that the design and layout of one of the houses was meeting the needs of each resident. These works included the installation of a bathroom, kitchenette and living space for one resident and changes to the garden.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk management policy contained the information required by the regulations and had been reviewed and updated in line with the timeframe identified in the regulations. There was a risk register in place for each of the houses and evidence that it was regularly reviewed and updated.

General and individual risk assessments were developed and reviewed as required. There were systems for responding to emergencies and systems to identify, record, investigate and learn from incidents.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had policies and procedures in place in relation to infection prevention and control. They had also adapted existing policies and procedures to guide staff practice during the COVID-19 pandemic.

Staff had completed hand hygiene, infection control and PPE training.

The premises was clean and there were cleaning schedules in place to ensure all areas of the house were regularly cleaned.

There were supplies of PPE available and systems in place to ensure there were always adequate stocks available.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

On review of a sample of plans, the inspectors found that 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.

Judgment: Compliant

Regulation 6: Health care

Residents had their healthcare needs assessed and care plans developed as required. Residents were provided with health action plans which included a comprehensive assessment of their healthcare needs and identified supports required to meet those needs. The health action plans were reflective in nature and encompassed a section for evaluation, ensuring appropriate and timely review of the plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

The designated centre's guidelines on how to support persons with behaviours of concern had not been updated since September 2017.

Documentary evidence to demonstrate that the quarterly reviews by the behaviour of concerns monitoring group (as per the centre's policy) had been completed was insufficient.

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.

Improvements were warranted to ensure that evidence of all alternative measures considered were documented in the centre's review of restrictive practices to clearly demonstrate that, at all times, the least restrictive procedure for the shortest duration was used.

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

Judgment: Not compliant

Regulation 8: Protection

Residents were protected by appropriate safeguarding policies and procedures in the centre. Residents were assisted and supported to develop their knowledge, self-awareness, understanding and skills needed for self-care and protection through

easy-to-read booklets made available to them.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, the rights of the residents were being promoted. There was evidence to demonstrate that residents were consulted and made decisions regarding the service and supports they received.

Matters relating to the resident's rights regarding assisted decision making have been dealt with in Regulation 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Glen 3 OSV-0003727

Inspection ID: MON-0028130

Date of inspection: 19/11/2020

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • CNM2 post is advertised and closing date is 5t January. Applicants will be shortlisted and interviews will be scheduled in an appropriate timeframe. • SN vacancy x 1 was filled on 15th of November with a local transfer. SN returned from sick leave and commenced in Designated Centre on 2nd December. • SN Vacancy x 1 is currently filled by a relief staff nurse carrying out 39 ours per week. Recent shortlisting from SN advertisement yielded no suitable applicants that met the criteria. Plan to re-advertise early 2021. • HCA vacancy is redeployed to Isolation Hub during pandemic of Covid-19. Plan is to return once Isolation Hubs no longer required. Currently being filled by a relief HCA who works 39 hours per week. • SCW vacancy .5 was recently advertised but no suitable applicants from interviews. Plan to re-advertise in early 2021. • The PIC/PPIM will ensure that roster changes or support will be highlighted on the actual rosters. • All relief staff are based on one bungalow roster. The PIC/PPIM will ensure that it is made clear by their name that their position is relief and their full name is included. If they are rostered to cover another house in the designated centre the PIC/PPIM will ensure that their full name is included. • Currently there are no agency staff in the designated centre, but when there is the PIC/PPIM will ensure that their full name and name of agency will be present.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and	

staff development:
• Out of the 10 staff that were due fire refresher, 9 have completed. 1 staff is on extended leave and this will be prioritised upon return in 2021. The training department has scheduled further dates for fire training via Zoom and 7 allocated places will be provided for St. Louise's per month. The PIC/PPIM will ensure that staff who are needing refresher training or new starters are scheduled promptly.
• 1 staff is still due refresher manual handling but is on extended leave and it will be prioritized upon return in 2021.
• 14 staff are still due refresher food safety training. The training department has secured a contract with the Food Safety Company and the invoice has just recently been paid. Awaiting the allocation of the rolling log of level 2 food safety course. The training department has assured the PPIM that this designated centre will be given adequate allocations. The PIC/PPIM will ensure that once obtained that all staff will be up to date.
• The PPIM has been in contact with the Training Department who said they are awaiting approval from the executive for Managing Challenging Behavior training face to face for 4 people at a time during current Covid-19 restrictions. This will be prioritized for staff in higher risk areas and then there will be some different levels of training delivered via zoom to lower risk areas. Once allocation confirmed the PIC/PPIM will prioritise staff to attend this training.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PPIM has been in contact with Quality and Risk Officer and she has assured that the Annual Review Report will be completed by the end of February.
• 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.
• Audit schedule has been developed which will review documentation such as care plans, PDPs etc.

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.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

• The PIC/PPIM will continually drive and review PDPs, adapting goals in line with current pandemic.
• Residents and their support circle will be involved with PDPs.
• Some staff have been identified who are 'bright spots' and will support key workers and residents in developing more fulfilling goals.
• John Armstrong modules are available to staff which is online modules on social role valorization and achieving the 'good life'. The PIC/PPIM will encourage staff to view these modules as part of training needs analysis.
• A subgroup has been developed in St. Louise's to look at 'rethinking day services' and feeds back to a wider service group. This group aims at how we can deliver day services differently and ensure people reach a good quality of life. Focus is also looking at meeting PDP goals, evening activities and weekend activities.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• New guidelines on how to support persons with behaviours of concern have been developed for the service in November 2020. The PIC/PPIM will ensure all staff read and are familiar with this guideline.
• Quarterly reviews by the behaviour of concerns monitoring group recommenced in November 2020. A manager from the designated centre now sits on this group. Minutes will be fed back from manager on quaterly basis.
• The CNS in behaviour has returned from redeployment and commenced supporting caseload for designated centre. A meeting was held on 25/11/20 with PPIMs and CNS in Behaviour and priority was given based on positive behaviour support plans being out of date or number of incidents recorded. CNS has carried out a thorough review of one residents plans and a core review held with a number of MDT members on 9/12/20 December. A number of recommendations are in place and being followed through.
• The PPIM has liased with the Education and Training Department who has assured that a risk assessment has been submitted for face to face training in small groups for studio

3 Managing challenging behaviour training. This is planned to start in January and will be prioritised to staff first working in high risk areas. Lower risk areas may commence a part zoom course. The PIC/PPIM will allocate staff as places become available.

• Risk reduction plans have been put in place to clearly show steps taken to try to reduce restrictive practices. Quaterly Restrictive Practice review meetings will continue with MDT members.

• 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 again discussed here.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	01/04/2021
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	01/04/2021
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Substantially Compliant	Yellow	01/04/2021

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	01/01/2021
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	01/03/2021
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 and effectively monitored.	Substantially Compliant	Yellow	01/01/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and	Not Compliant	Orange	01/03/2021

	safety of care and support in the designated centre and that such care and support is in accordance with standards.			
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	01/12/2021
Regulation 31(1)(d)	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 serious injury to a resident which requires immediate medical or hospital treatment.	Substantially Compliant	Yellow	01/01/2021
Regulation 31(3)(a)	The person in charge shall	Not Compliant	Orange	01/01/2021

	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.			
Regulation 31(3)(d)	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 injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	01/01/2021
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	Substantially Compliant	Yellow	01/04/2021

	behaviour.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	01/04/2021
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	01/04/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Yellow	01/04/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Substantially Compliant	Yellow	01/04/2021

	this Regulation all alternative measures are considered before a restrictive procedure is used.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	01/04/2021