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 1
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	05 August 2021
Centre ID:	OSV-0004907
Fieldwork ID:	MON-0025746

About the designated centre

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

Glen 1 designated centre is located on a campus setting and provides a residential service for 18 adults with an intellectual disability who require moderate to high support interventions. The provider applied in March 2020 to register an additional building for the purpose of isolation for residents during the COVID-19 pandemic. This building can accommodate a maximum of six residents. The centre is located in a suburb of Co. Dublin with access to a variety of local amenities. The centre is nurse led and residents are supported 24 hours a day by a team comprising of a person in charge, clinical nurse manager, staff nurses, social care workers, healthcare assistants and household staff. Residents are supported to engage in a range of activities which were meaningful to them both in the community and on the campus where the centre is located. The designated centre consists of four buildings, three of which are bungalows. In the bungalows, there is a main living room and a smaller sitting room where residents can meet family and friends or have some personal space. There is a shared dining space and kitchen where residents can prepare or choose snacks of meals. There are two bathrooms and one toilet and six bedrooms with a sink in each bungalow. Each bungalow has a shared garden area which leads into the main centre grounds. There is a restaurant within the inner garden of the main centre which is accessible to all residents, staff, families, friends and volunteers and offers a wide variety of food to suit all dietary requirements. There is also a quiet reflection room were residents can express their spiritual needs.

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 5 August 2021	9:25 am to 6:20 pm	Erin Clarke	Lead
Thursday 5 August 2021	9:25 am to 6:20 pm	Sarah Mockler	Lead

What residents told us and what inspectors observed

The inspectors had the opportunity to meet with 16 residents and several staff members during the day of the inspection. Residents were supported by staff while interacting with the inspectors. To gather a sense of what it was like to live in the centre, the inspectors carried out brief observations, staff discussions, and an in-depth documentation review. The inspectors noted that residents appeared happy, comfortable, and had a good standard of care and support provided to them. This inspection took place during the COVID-19 pandemic, and as such, the inspectors adhered to national best practices and guidance with respect to infection prevention and control. To decrease footfall in the centre, each of the inspectors visited two locations in the centre, and they reviewed documentation in a separate office location. The designated centre also consisted of an isolation unit that was registered for isolation purposes during the COVID-19 pandemic.

On arrival to the setting, it was noted by the inspectors that each bungalow was well kept, with mature gardens surrounding each home. Each of the homes consisted of one large communal kitchen, dining and living room, a separate sitting/visitors room, six bedrooms, several bathrooms, laundry room, staff office, and staff changing room/bathroom. The bungalows were clean and homely and very well kept. A back garden led from each bungalow into a communal courtyard. The gardens were brightly painted with well-maintained seating areas and flower beds. This area could be accessed from a sliding door in the communal living room, and staff reported that residents enjoyed spending time in the garden.

One of the bungalows supported individuals with late-stage dementia. On arrival at the door, the inspector was warmly welcomed by a staff member. The immediate impression of the home was of one of calmness. Music was softly playing in the background for residents. Two residents were relaxing in the sitting room, and others were in their bedrooms. The residents had access to a sensory room, and a resident was relaxing there listening to soft music while different light displays were projected around the room. Residents seemed to be very comfortable and content. As identified in a previous inspection and also in the provider's annual review, there was limited storage in the residents' homes for their specific equipment, such as soft chairs. Much of the equipment needed for the residents was stored in the residents' communal space. Observations indicated that all this equipment was stored along the back walls of this space.

The inspector visited a second home, and the assessed needs of the residents here differed from the first bungalow. A staff member and resident warmly welcomed the inspector. The resident was eager to show the inspector around their home. In this home, three residents were sitting in the living room together watching a music show. Again, the bungalow was well kept, and residents' bedrooms were decorated to suit individual preferences and needs. Other residents were observed to be in their room completing preferred activities. Although there were a number of bathrooms available to residents, there was only one working accessible shower for

the six residents. One bathroom had an accessible bath which was out of commission for quite a period of time. Staff reported that personal care was taking up a large part of the day as residents had to wait to access the shower. Residents were observed to smile and request assistance from staff when needed. Staff were prompt in their response and kind and gentle with the support and care they provided. During this visit, the inspector had the opportunity to review residents' individual personal plans, which were kept on the residents' computer tablet. The residents were also keen to review the associated videos with the inspector. The plans reviewed indicated that residents were being supported in many different activities in the home environment, such as arts and crafts, flower arranging, cocktail nights, and beauty treatments. Residents were observed to laugh and point out their friends and familiar staff members while watching it.

When the inspector visited the third bungalow, residents were watching a concert on the television and were taking rests in their bedrooms and communal living spaces. Residents appeared to be content and familiar with their environment. On observing residents interacting and engaging with staff using non-verbal communication, it was obvious that staff clearly interpreted what was being communicated. For example, staff understood when a resident was looking for a particular item and helped them search their bedroom until it was found. During conversations between the inspector and the residents, staff members supported the conversation by communicating some of the non-verbal cues presented by the resident. One resident happily showed the inspector their personal plan, which was personalised with photographs and homemade crafts. The inspector learned that the resident was being supported to open their own bank account and applying for a travel card.

No residents were residing in the isolation unit during the inspection. The isolation unit was registered for a maximum of six residents in the event they were unable to effectively self isolate in their own homes. While the unit was only to be used for short periods for isolation, the inspector did identify premises and fire precaution issues with the building that needed addressing, which are discussed in greater detail under the 'quality and safety' section of the report. Furthermore, the discharge processes required a review to ensure residents that required to self isolate after a hospital stay stay or as a result of being a close contact were guided by national guidance.

Eighteen residents were supported by staff and family members to complete a questionnaire in relation to their experience of care and support in the centre in advance of the inspection. The feedback in these questionnaires was mostly positive, with some residents including areas where they would like to see improvements. Overall, residents indicated that they were happy with the comfort in the centre, their access to shared areas and a garden, and the staff. For example, they included comments like, "I am very happy", "I love spending time in the garden", "I love my games and new table". On the other hand, many residents included things they would like for their home or would like changed about the food. For example, "I would like my bedroom painted..and sensory lights", "I would like my bathroom fixed so I can take a bath in the evenings, "I would like staff to cook for me for a change in taste and quality" from the canteen. And also requested "an

extendable dining table for a more pleasant dining experience".

Family members of residents were complimentary towards staff support in the centre. Their questionnaires described staff as "wonderful, kind and considerate", with one residents' family member questionnaire saying their loved one had a smile for staff when they returned from a visit, which the family member felt meant the resident was happy and pleased to return to their home.

Residents' questionnaires described activities they were participating in and named some activities they would like more opportunities to attend. Activities they were currently enjoying included 'Golden Girls' active retirement group, baking via computer classes, getting active classes and reminiscing therapy. Examples of activities listed as ones they would like to take take part in more often included the cinema, shopping, going out for meals, aromatherapy and going on holiday. A number of residents referred to the impact of restrictions relating to COVID-19 on their access to activities, with a number of them referring to how much they were looking forward to accessing these activities again. Some residents also referred to how they missed attending their day service and were looking forward to its reopening.

There were complaints policies and procedures in place in the centre, and residents indicated in their questionnaires that they were aware of who to go to if they had any concerns. The annual review had accurately identified that complaints were being made by residents and staff in relation to limited Internet connection but had not been recorded or followed up in line with the policies and procedures. The inspectors were informed that the provider had responded to these complaints by investing in Internet infrastructure. However, this had not fully resolved the Internet connectivity issue resulting in some frustrations for residents, especially as there was a reliance on remote classes with the closure of the day service.

In summary, residents appeared comfortable and content in their homes and the provider had self-identified and implemented positive changes to the service to provide better outcomes for residents. For example, the annual review had identified many areas of improvements, including premises works, staff training needs, risk management requirements, to name but a few that were in line with the findings of this inspection. However, some findings from previous inspections remained outstanding. This will be discussed further in the report. Although care and support was being provided in line with residents' assessed needs, the inspectors were not assured that the designated centre met the assessed needs of all residents. The next sections of the report will discuss the findings of this inspection.

Capacity and capability

Overall, the inspectors found that the provider and local management were striving to ensure that residents living in the designated centre were in receipt of a good quality and safe service. The service was led by a capable person in charge who was supported by two clinical nurse managers. The person in charge had commenced their post in March 2020. They were found to be knowledgeable in relation to residents' assessed needs and advocated for improvements to ensure residents were happy, safe and making choices in relation to their day-to-day lives. However, on the day of the inspection, the inspectors found that improvements were required to ensure all residents experienced a positive lived experience in the centre at all times. The inspectors also found that some of the governance and management systems in place required reviewing to ensure they were effective. In relation to fire precautions and premises, the inspectors found that improvements were warranted to ensure that residents could enjoy living in a safe, clean, and homely environment. The latter findings are discussed in the quality and safety section of the report.

This announced inspection was announced two weeks in advance of the inspection date to afford residents and families the time to participate. The purpose of the inspection was to follow up the inspection in June 2020, whereby an update was required of the actions identified from the previous inspection in advance of the designated centre's registration renewal. As previously mentioned, the designated centre also consisted of an isolation unit, a previously used day services building located on the campus. This inspection also aimed to review the COVID-19 arrangements, premises and water treatment systems in place for the isolation unit. The isolation unit was registered in April 2020 following an application to register made in line with the specific COVID-19 arrangements the Chief Inspector of Social Services put in place in response to an anticipated need for isolation facilities for residents living in designated centres during the pandemic.

The inspectors found that some of the improvements from the last inspection had been completed and had resulted in positive outcomes for the residents. For example, a clinical nurse specialist in behaviour had been repatriated back to their post following a redeployment during the COVID-10 pandemic, and the process of reviewing behaviour support plans has commenced.

The provider had completed an annual report in January 2021 of the quality and safety of care and support in the designated centre, which families had been consulted with regarding their views. Residents views, however, had not been captured as part of this review to ensure their opinions, ideas, and suggestions of how they would like to live their lives also fed into the quality improvement plan. The annual review reflected on the areas of improvements identified in the previous inspection, such as staff training, supervision and premises issues. However, to ensure the effectiveness of the annual report, the actions' section on the report required a review. The inspectors found that where the report had identified outstanding issues backdating to 2018 relating to the premises, the action plan did

not provide a clear plan of action or time frame to complete the tasks.

The inspector found that formal supervision was occurring in line with the organisation's policy; the provider reviewed this policy in May 2021 to change the frequency of supervision from six times yearly to twice yearly. A schedule of supervision was in place with a clear delegation of supervisees to supervisors. A sample of notes reviewed indicated that good quality supervision was occurring that promoted staff development to meet residents' specific needs best.

Improvements were found to be required in relation to staff accessing training and refresher training; there remained a number of staff who required training/refresher training, and these will be detailed later in this report. Staff training had also been identified in two previous inspection reports and the provider in their most recent annual review. Although there was a system to record mandatory training such as safeguarding, fire safety training, and manual handling, this system failed to record and identify specific training in line with residents' assessed needs. For example, there was no record in relation to staff receiving dementia or dysphagia training. The person in charge had identified and escalated specific training needs required for the staff team; however, several staff were still required to complete this training.

Inspectors found that the person in charge and staff team were motivated to ensure the residents were receiving care in line with their assessed needs. Nursing care was available to all residents in their homes, with additional support and care provided by healthcare assistants. At the time of the inspection, there were three whole-time equivalent staff vacancies. Currently, the existing staff team, including the person in charge, provided cover for staff vacancies which resulted in the continuity of care for residents. A sample of staff rosters reviewed indicated there were sufficient staff in place to meet the resident's support needs.

Registration Regulation 5: Application for registration or renewal of registration

The application for registration renewal and all required information was submitted to the Chief Inspector within the required time-frame.

Judgment: Compliant

Regulation 14: Persons in charge

The inspectors found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives. The person in charge was a clinical nurse manager and was in post since March 2020. They met the regulatory requirements to hold the post of person in charge and had completed

a post registration management qualification. The inspectors were assured that the person in charge was escalating concerns and areas for improvement to senior management.

Judgment: Compliant

Regulation 15: Staffing

As previously mentioned there were three staff vacancies on the day of inspection. The provider was in the process of recruiting to fill these. The existing staff team, including the person in charge, and relief staff were currently completing shifts to ensure a full complement of staff was available to support residents at all times. An actual and planned roster was in place to ensure staffing levels were sufficient at all times.

Judgment: Compliant

Regulation 16: Training and staff development

A number of staff required initial and refresher training in mandatory training. This had been identified in the provider's most recent annual review. The training matrix reviewed by the inspector indicated the following:
- 1 staff required fire safety training
- 1 staff required food safety training
- 3 staff required refresher hand hygiene training
- 1 staff required safeguarding training; 8 staff required refresher training
- 21 staff required managing challenging behaviour training; 3 required refresher training.

As previously discussed, training in line with residents' specific individual assessed needs was not always identified, or on the training matrix, and there was no system in place to track and identify when this training was completed or due. For example, residents' assessed needs possibly indicated that staff required specific training in dysphagia, epilepsy, dementia, bespoke positive behaviour support training to name but a few. Although there was some evidence that a number of staff had completed some of this training, it was difficult to determine if all staff supporting the residents had completed the necessary training. The inspectors were also informed that access to training sessions had been limited with the re-configuration of the day service building into an isolation unit.

Judgment: Not compliant

Regulation 23: Governance and management

The provider was completing six-monthly and annual reviews of care and support for residents in the centre as required by the regulations. These were identifying areas for improvement in line with findings of this and previous inspections. There was evidence that a number of the actions following these reviews had been followed up on and completed. And that these were leading to positive outcomes for residents.

There was however, limited evidence of residents' input into the quality of care and support in the centre, as the report noted that feedback surveys had not been completed with residents. The inspectors found that the residents and their advocates had a number of suggestions for the continuous improvement of the centre.

There was a local auditing system in place by the person in charge, supported by the clinical nurse managers, to evaluate and improve the provision of service and to achieve better outcomes for residents. The audit system included monthly household audits, personal plan audits and management of medicines audits but to mention a few. Some further improvement was required to ensure actions were completed in a timely manner. For example a medication audit rolled over actions from the previous year which had not been identified by management.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed on May 2021 and contained the information set out in Schedule 1. A copy had been submitted to the Chief Inspector as part of the application to renew registration of the centre. It reflected the services and facilities provided at the centre, including the isolation unit. The statement of purpose detailed the rationale for admission to the isolation unit, including residents who have to move from their own homes due to other residents testing positive for COVID-19.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the designated centre was maintained. The Chief Inspector was given notice in writing of all of the required incidents in line with

the requirements of this Regulation.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure in place and a nominated complaints person in the centre. A record system was made available to record complaints in line with regulatory requirements. From a review of complaints, inspectors found that the documents included the issue, the complainant, the date the complaint was made and who the complaint was made to. However, what was not recorded was whether residents were satisfied that the matter was resolved to their satisfaction, for example, Internet connectivity. This is an important feature of the complaints management and oversight process prescribed in the Regulations.

In their questionnaires, residents indicated that if they were unhappy about anything, they would speak to staff or go to a member of management. One resident who had used the complaints process indicated they were happy with how their complaint was dealt with; however, they felt it took a long time to resolve.

Judgment: Substantially compliant

Quality and safety

The inspectors found that overall, the residents' wellbeing and welfare was maintained by a good standard of evidence-based care and support. It was evident that the person in charge and staff were aware of residents' needs and knowledgeable in the care practices required to meet those needs. Overall, the care and support provided to residents were of good quality. However, to ensure the safety and wellbeing of residents at all times, the inspectors found that some improvements were required to premises, risk management procedures and fire precautions. In relation to fire precautions and premises, the inspectors found that improvements were warranted to both the isolation unit and main bungalows to ensure that residents could enjoy living in a safe, clean, and homely environment.

The services manager informed the inspectors of planned advancements for the centre including, developing the dementia model of care with dementia-specific training for staff and activation programmes for residents. In addition, to further support residents with dementia, the provider had sourced specialist technology in the form of an interactive light projector proven to help staff promote stimulation through specialised games. The designated centre would also be taking part in a pilot trial for an online care plan commencing January 2022. It was evident that the

provider was reviewing the services provided in line with residents changing needs; however, it was apparent during the inspection that the living environment for some residents did not reflect their needs. This is discussed under regulation 17 premises and regulation 5 assessment of need and personal plans.

In relation to health care needs, each resident had health care management plans for all relevant health care needs. There was evidence that these health care plans were taking into account changes in circumstances and new developments. For example, if there were changing needs in relation to eating, feeding, or drinking, a speech and language therapist completed an assessment to ensure the correct supports were provided. For the social care needs of residents, there were person-centred plans available for each resident in relation to community relationships and social inclusion. The residents' personal plans also had the annual person-centred planning meeting. With the resident at the core of the process, this planning meeting developed community inclusion and lifestyle goals for the year. The goals identified the supports the person needed to achieve these goals and a time frame identified to achieve these goals. It was noted that not all residents had up to date personal plans, and these were due for updating in September 2021.

Overall, residents were protected by the risk management policies and procedures in the centre. The provider's risk management policy contained the required information as set out in the regulations. Some improvements were required regarding the updating of all risk documentation to reflect risk management practices. For example, the centre’s risk register did not fully reflect all the centre’s risks and some identified risks were not fully risk rated. For example, behaviours of concern were listed as a risk, however, there was no corresponding initial risk rating. The gaps in the documentation did not pose any immediate risk to any individual.

Inspectors reviewed the systems for residents to access and retain control of their personal property and possessions. The majority of residents in the centre did not have an account in a financial institution in their own name. However, the provider had started to address this, and eight residents had recently opened bank accounts with other residents in the process of opening accounts. The inspectors reviewed a sample of residents' daily finances and audits. They found that record balances accurately reflected receipts and outgoings, and there was good evidence of oversight and monitoring of these records.

There were fire management systems in place to keep residents safe. Suitable fire equipment was available and regularly serviced and there were means of escape that were kept unobstructed, and emergency lighting was in place as required. Each resident had a personal emergency evacuation plan in place. Due to the complex mobility needs of some of the residents in the designated centre, there was an overarching fire plan for the campus and then individual plans for each of the individual homes. This overarching plan had last been updated in 2016. On review of the fire drills it was found that in some homes, elements of the fire evacuation fire plan had not been put into practice, for example utilising a progressive fire evacuation procedure. In addition to this, risks were being identified in drills, such as long evacuation. Follow up drills were not always completed in a timely manner to ensure these risks were mitigated. The provider discussed that there was a long

term plan in place in terms of providing individual fire exits from each bedroom to address this risk. However, interim measures did not ensure that fire drills were reflective of the policy or practiced effectively to ensure staff were able to put policy into practice.

The inspector completed a walkthrough of the isolation unit; the building consisted of six bedrooms, three bathrooms, kitchen facilities, a sitting room, office space and a laundry room. The provider had ensured appropriate water management systems and testing were in place to mitigate the risk of Legionella bacteria due to the building being unused for periods of time. The building had designated donning and doffing stations for personal protective equipment (PPE) and appropriate hand washing and sanitising facilities. While the isolation unit appeared throughout as a day service in design and layout, it was noted as a suitable premise for the purposes of supporting residents with COVID-19 to self-isolate for a short stay. However, the inspector identified that two of the six rooms assigned as bedrooms were unsuitable for the use of residents. These rooms were currently being used as storage for office files, furniture, old equipment and items for disposal. In addition, two bedroom fire doors did not have self closures fitted to ensure they closed in the event of a fire, with one of the bedrooms also being an emergency exit. The inspectors brought these concerns to the service manager during the feedback session.

A sample of positive behaviour support plans were reviewed by the inspector. These plans were found to be sufficiently detailed to guide staff practice and to ensure residents were supported as best as possible. Staff were supported by a Clinical Nurse specialist in behaviour and plans were regularly updated when required. Data was maintained to track the effectiveness of the strategies put in place. Minimal restrictive practices were in place, these were regularly reviewed by the multi-disciplinary team. Restrictive practices were based on the centre and national policies. There were gaps identified in the staff training, however, this has been addressed under regulation 16, staff training and development.

There was an up-to-date safeguarding policy in place. Overall, incidents, allegations, and suspicions of abuse at the centre were investigated in accordance with the centre's policy. There were gaps identified in the training however this is reflected under regulation 16. Staff were familiar with safeguarding plans and were observed to fully support residents in line with their assessed needs.

Regulation 12: Personal possessions

Arrangements were in place for residents to maintain control over their personal belongings. For example, residents had storage facilities provided in their bedrooms while lists of their personal property were also maintained. The provider was conducting regular audits of money which was spent on behalf of residents to ensure safe practices were employed at all times. Residents were also being supported to open financial banking accounts in their own name.

Judgment: Compliant

Regulation 17: Premises

Overall the premises were kept to a high standard, and the inspectors found that there was adequate private and communal space for residents and that the houses were comfortable and that the physical environment was clean. Some areas were identified for improvement as already known to the provider. However, these did not have a timebound plan for the issues to be addressed. In addition, the inspectors identified further premises issues in the isolation unit.

- There was insufficient suitable storage space in one of the bungalows with large mobility aids belonging to residents stored in the communal area. This was first identified and actioned in 2018.
- One bungalow did not have sufficient baths and showers suitable to meet the needs of residents.
- Two assigned bedrooms in the isolation unit were not fit out to accommodate residents.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

The inspectors reviewed the admissions and discharges of the isolation unit; there had been 48 admissions since March 2020 and a maximum of five residents at one time. Residents had stayed in the isolation unit for periods of time ranging from two days to 22 days.The inspector requested a copy of the admission and discharge policy for the unit, which was received after the inspection. The policy, dated April 2020, required review to ensure it was up to date and it aligned with national guidance regarding isolation time frames from the Health Protection Surveillance Centre (HPSC). It was unclear from the discharge sheet the rationale for delayed discharges for residents who had tested negative or required self-isolation for 14 days post hospital admission. The inspectors found the policy omitted details relating to the discharge of residents that were medically well or COVID-19 negative to guide discharge practices.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management, and ongoing review

of risk. There was a risk register and general and individual risk assessments were developed and regularly reviewed. However, the risk register required review to ensure it was reflective of the current risks in the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Arrangements were in place for the protection against infection, staff were seen to wear appropriate PPE. Organisational COVID-19 contingency plans were in place and a local centre specific COVID-19 contingency plan. The provider had good arrangements for contacting and liaising with public health. A COVID-19 information folder was maintained which contained the most up-to-date public health guidelines

The inspector found that there were appropriate facilities for hand hygiene, including hand gels and the person in charge stated there was plentiful supplies of PPE in both the bungalows and isolation unit.

Judgment: Compliant

Regulation 28: Fire precautions

There was suitable fire equipment provided and it was serviced as required. There were means of escape and emergency lighting in place. Improvements were required in relation to fire drills. Although fire drills were occurring, there was insufficient evidence to indicate if fire drills were occurring on a frequent enough basis to address identified risks. The centre had residents with complex mobility needs which would indicate that regular fire drill practice was essential to ensure fire evacuation procedures were applied in practice. Although, there was a long term plan to address the identified risk by the provider, interim arrangements needed improvements.

The isolation unit fire containment measures required reviewing, fire door closures were not in place for all bedrooms. Weekly fire checks had not been completed for the isolation unit since February 2021.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

All residents had a pre-admission assessment prior to them coming to live in the

designated centre. This helped to ensure that the centre could meet the residents' needs. Following admission, the resident underwent a nursing and social care assessment that was used to develop their individual care plan. Records showed that residents and/or their families were involved in developing and reviewing their care plans.
The inspectors viewed transition plans for two residents who had been identified for community living in line with the resident's needs and expressed wishes. The inspectors were satisfied that while campus living was not best suited for these residents due to their demographics and capability, plans were in place and discussed at transition meetings to identify appropriate alternative homes. However, information made available to the inspectors after the inspection highlighted that while one resident's goal was to move to a new home, this plan was not formalised and the centre was not currently meeting that resident's assessed needs.

Judgment: Substantially compliant

Regulation 6: Health care

The health care needs of residents were set out in their personal plans and adequate support was provided to residents to experience the best possible health. Appointments with allied health professional were facilitated with records maintained of these.

Judgment: Compliant

Regulation 7: Positive behavioural support

Appropriate supports were in place for residents that required specific behaviour support strategies. There was evidence to indicate that restrictive practices were applied in line with national policy.

Judgment: Compliant

Regulation 8: Protection

There were systems in place in the centre to ensure that residents were protected and safe from abuse. These systems were described in the registered provider's safeguarding policy and procedures. Staff were observed to put safeguarding plans into practice.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glen 1 OSV-0004907

Inspection ID: MON-0025746

Date of inspection: 05/08/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge shall ensure all staff have access to and complete appropriate training including refresher training. The PIC has updated the training matrix to include records of bespoke and training specific to individual assessed needs. The PIC will maintain up to date training records to track and identify when training is completed or due. The person in charge has reviewed the training records and developed a training needs analysis for the designated centre including mandatory training and training specific to individual assessed needs. Dates have been secured for fire training and food safety training Staff have been allocated to complete safeguarding training and hand hygiene training via HSE Land. The training department will schedule appropriate training and refresher in Managing Challenging Behaviour specific to the needs of the designated centre. One staff remains on long term sick leave but upon their return the PIC will ensure they complete all necessary training.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC will ensure that all residents will be facilitated to participate in an annual survey This information will be analysed and will be reflected in the Annual Review Report The PIC will ensure actions from audits will be monitored and followed through to ensure actions are addressed in a timely manner.	

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The PIC has reviewed the complaint and updated the complaints log to indicate the outcome of the complaint , discussion with the residents and the residents satisfaction with the outcome. The PIC will ensure going forward that all complaints are followed through appropriately in line with the regulation.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In conjunction with the installation of the Fire Escape Doors from the bedrooms the fitted furniture built in unit around the radiators etc. currently in place on the external wall will be removed. This will release valuable additional floor space in the 6 bedrooms which can be utilised for storage of the resident's personal mobility aids etc.- please see compliance plan for regulation 28 for time line

Following the review of the wishes and preferences of the residents budget has been approved to install a new bath.
An application to vary for OSV 0004907 has been submitted in relation to closure of the isolation unit .

Regulation 25: Temporary absence, transition and discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
The person in charge shall ensure that the discharge of a resident from the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose. The Procedure for Admission and Discharge during COVID-19 will be reviewed by the Infection Prevention control committee to bring up to current HSPC guidelines

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC will review and monitor the designated center's risk register to ensure it is reflective of all the centres risks

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC has developed a schedule of fire drills to address identified risks for the resident's. Fire drills will be recorded in line with policy and fire evacuation drills.

The PIC will ensure the fire plan is reviewed and informed to all staff working in the designated and that the plan will be applied for all fire evacuations
The fire plan will be included for discussion at all staff meetings and induction for new staff

The long term projected programme to address the fire evacuation is as follows:
1. Completion of Tender Package and Seek Tenders will be completed by - 30th September; the Tender Returns are due By - 21st October.
2. Place Contract Week beginning- 25th October.
3. Commence on Site (subject to manufacturing lead in times for Door sets currently we are advised it is 6-8 weeks) Mid December – Early January Works on site estimated to take 3 weeks (Phased).
4.
. An application to vary for OSV 0004907 has been submitted in relation to closure of the isolation unit

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC will ensure that where it is identified that a residents assessed needs cannot be met or that it is a resident's wish and preference to transfer to alternative accommodation that an Individual Preference & Needs Assessment will be complete and a formal transition plan will be developed in line with the persons wishes .

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.	Not Compliant	Orange	31/12/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/03/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2022
Regulation 23(1)(a)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/11/2021

	designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/11/2021
Regulation 25(4)(a)	The person in charge shall ensure that the discharge of a resident from the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/10/2021
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the	Substantially Compliant	Yellow	31/10/2021

	resident's quality of life have been considered.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	31/03/2022
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	13/09/2021
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/10/2021