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:	Glasthule
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	11 September 2019
Centre ID:	OSV-0004136
Fieldwork ID:	MON-0022568

About the designated centre

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

Glastule designated centre is located in a suburban area of South County Dublin and is comprised of three individual units. It provides 24 hour residential care to persons with intellectual disabilities and has capacity for supporting 14 individuals. All three units are community based and provide supports through a social care approach. The centre is managed by a person in charge who is supported in their role by a social care leader and a staff team which is made up of social care workers and carers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
11 September 2019	10:00hrs to 18:30hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

The inspector met and spoke with a number of residents who were availing of the services of the centre and observed interactions from staff. Overall, those met with appeared to be happy with the service they were in receipt of and staff were observed to treat residents with kindness and respect. The inspector received five completed questionnaires from residents and family members which explored areas such as general satisfaction with the services provided, accommodation, food and mealtime experience, arrangements for visiting, residents' rights, activities, care and support, staffing arrangements, and complaints. Overall, the inspector found that there were high levels of satisfaction communicated through the completed questionnaires, however, in some cases residents (or their representatives) raised concerns regarding their personal safety and how they had previously experienced peer to peer incidents of an abusive nature.

Capacity and capability

Overall, the inspector found that this centre had not protected some residents from experiencing abuse and through a lack of action on the part of the registered provider, a number of residents continue to experience incidents of a safeguarding nature on a regular basis. The centre is made up of three units and these concerns relate to two of these units. In the other unit, residents were found to experience a very positive quality of life and to live active and meaningful lives. The lives of residents living in the other units involved regular and persistent difficulties with protection, safety, personal rights, and general welfare. This report outlines the findings from an inspection which took place in a context of a follow up to a risk based inspection which was carried out in the centre in June 2019.

The inspector met with the person in charge of the centre at the time of the inspection and found that they were very knowledgeable of the relevant legislation, regulations and national policies. The person in charge had the appropriate experience and qualifications as required by the regulations and demonstrated a commitment to improving the lives of residents in the centre. The inspector found, however, that the person in charge had responsibility for the management of two designated centres and this was soon to be increased to include a third centre. This arrangement was found not to be an appropriate arrangement to ensure effective oversight of the centre.

A review of staffing arrangements found that there were a number of vacancies in the staff teams deployed in the centre. As a result, there was a reliance on relief staff members to supplement the permanent staff team and to ensure minimum staffing levels were maintained. A review of staff duty rosters for September 2019

found that 16 different relief staff members worked a total of 52 shifts in this period which did not facilitate continuity of care and support for residents. A number of staff members spoken with by the inspector raised concerns relating to the use of relief staff in the centre and the difficulties which arose from this approach to rostering staff members.

The inspector reviewed staff training records and found that there were a number of areas of mandatory training with identified deficits. There were deficits in five of seven training areas identified by the person in charge as being mandatory. For example, five staff members had not completed training or refresher training in the area of fire safety. There was a plan in place to address these deficits and in a number of instances staff members had been scheduled to attend the required training.

A review of the arrangements for the supervision of staff was completed by the inspector who found that while there were appropriate systems in place for the informal supervision of staff, requirements for the formal supervision of staff members as set out in the organisation's policy on this matter were not being met. A number of staff files were reviewed and it was found that staff members were not in receipt of one-to-one supervision on a quarterly basis as required.

The inspector reviewed the governance and management arrangements in place in the centre and found that the governance systems employed did not ensure that service delivery was safe, of a high standard and appropriate to residents' needs. While the registered provider was aware of the areas of non-compliance with the regulations, the inspector found that appropriate actions had not been taken to ensure that residents were protected and services of a satisfactory standard were provided. The inspector found that the local management team were committed to addressing the identified non-compliances, however, there was a general lack of, or delayed, response from the registered provider in this regard.

A statement of purpose in place in the centre (dated July 2019) was reviewed by the inspector and found not to contain a number of areas outlined as being required by the regulations. An opportunity was provided to the person in charge to revise and update the statement of purpose and submit this to the inspector following the inspection. This revised version of the statement of purpose (dated 23 September 2019) was found to contain all required information.

The inspector found that there were two active volunteers supporting residents in the centre. The roles and responsibilities of the volunteers were set out in writing and they were supervised and supported by a team leader and a volunteer coordinator. Both volunteers had completed vetting disclosures and had received training in safeguarding and protection.

The inspector reviewed incident, accident and near miss records maintained in the centre and found that required notification of incidents to the Chief Inspector had been completed as required by the regulations.

A review of the arrangements for the management of complaints was completed by the inspector. There was policy in place (dated April 2016) along with a register of

complaints made. The inspector found that there had been nine complaints made to date in 2019, of which three had been resolved and closed off. All complaints made related to safeguarding incidents which had occurred in the centre or the dissatisfaction of residents with their living arrangements. The inspector observed that residents were encouraged and supported to make complaints where appropriate and found that complaints were followed up on and investigated in a reasonable time period, however, measures required for improvement in response to complaints made were not put in place in a number of cases. As highlighted in a number of areas of this report, the inspector found that some residents continued to experience abusive incidents and due to the absence of a response from the registered provider their complaints regarding these matters were not resolved.

Regulation 14: Persons in charge

The person in charge was found to manage more than one designated centre and as a result of the additional duties and responsibilities in other centres, the inspector found that appropriate governance and operational management was not maintained at all times in this centre.

Judgment: Not compliant

Regulation 15: Staffing

The inspector found that there were a number of vacancies in the staff team deployed in the centre. There was a significant reliance on relief staff members which impacted on the continuity of care and support received by residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector found that a number of mandatory training areas had identified deficits at the time of the inspection. There were:

- five staff members who had not completed training or refresher training in the area of fire safety
- three staff members who had not completed training or refresher training in the area of manual handling
- two staff members who had not completed training or refresher training in the area of safe administration of medication

- eight staff members who had not completed training or refresher training in the area of management of aggression and
- one staff member who had not completed training or refresher training in the area of children first.

In addition, the inspector found that appropriate systems were not in place to ensure that all staff members received formal one-to-one supervision in line with organisational policy requirements.

Judgment: Not compliant

Regulation 22: Insurance

The inspector found that the centre was insured against accidents or injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider was found to have failed to ensure that management systems were in place in the centre for the delivery of services which were safe and appropriate to residents' needs.

Judgment: Not compliant

Regulation 3: Statement of purpose

A revised statement of purpose (dated 23 September 2019) submitted to the inspector following the inspection was found to contain all required information as outlined in schedule 1 of the regulations.

Judgment: Compliant

Regulation 30: Volunteers

The inspector found that volunteers received information about their role and had access to relevant training including training on safeguarding and protecting

residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed incident, accident and near miss records maintained in the centre and found that required notification of incidents to the Chief Inspector had been completed as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector found that while there was a complaints process in place which was user friendly, fair and objective, measures for improvement in response to a number of complaints made had not been implemented by the registered provider.

Judgment: Not compliant

Quality and safety

The inspector reviewed the arrangements in place for supporting residents with their communication needs. There was an individualised approach adapted for supporting residents which included a support plan, referrals to allied health professionals where appropriate, and the use of alternative and assistive technology devices. There were several examples of good practice in this area which involved positive outcomes for residents. One resident met with demonstrated to the inspector how a member of staff had developed a range of reassuring video clips which were available on a computer tablet at all times to support them through a grieving period. The resident informed the inspector that they could access the video clips at any time and felt reassured each time which had improved their quality of life significantly.

A review of visiting arrangements found that there was an open and welcoming approach taken to support residents when receiving visitors. A number of residents were supported by the staff team to meet with visitors as part of community based activities while others were supported to meet with visitors in the centre. There were no restrictions found to be placed on any residents and there were appropriate

facilities in the centre for residents to meet with guests in private.

The inspector reviewed the general welfare and developments of residents and found that while there were some very positive examples of residents living active and meaningful lives, in two units of the centre residents were found to live in unacceptable and unsatisfactory circumstances. In these settings, the inspector found that residents were exposed to ongoing and significant numbers of incidents of a safeguarding nature. The inspector found that through limited response the registered provider had failed to provide appropriate care and support to residents. The inspector found that there was clear evidence of this in the areas of safeguarding and protection, governance and management of the centre, staffing, residents' rights, complaints management, in the assessment of residents' needs and in the placement of residents in the centre. Through reviewing documents which catalogued the abusive incidents, the inspector found that some residents were not experiencing a good quality of life while availing of the services of the centre.

A full walk through of the premises of the centre was completed by the inspector in the company of the person in charge. The centre was found to be clean and well maintained throughout. All three units were found to be homely and tastefully decorated and provided for an accessible and comfortable living environment. In the case of one resident's bedroom, however, the inspector found that a shower in an en-suite facility was not in working order.

The inspector reviewed the arrangements for the preparation of meals in the centre. Residents were found to be consulted with regarding menu planning on a weekly basis and participated in grocery shopping, meal preparation and dining room set up. The inspector observed a meal being prepared in one unit of the centre and found that it was nutritious and provided adequate amounts for all residents. There were snacks available for residents outside main meals and advice/guidance from allied health professionals were available for staff members assisting in preparing meals.

A review of the centre's risk management policy (dated July 2018) found that it did not contain a number of areas identified as being required by the regulations. The inspector found that there was a comprehensive risk register in place in the centre which had been developed since the time of the last inspection, however, a number of risks identified at the time of the inspection had not been assessed or listed as a risk. These included the absence of emergency lighting from certain areas of the centre and the absence of self-closing mechanisms for fire doors.

The inspector found while reviewing incident and accident records that there were several systems in place for recording incidents, accidents and near misses. All incidents of alleged abuse of residents were not being recorded on incident forms, however. This practice was not in compliance with the centre's own incident management policy (dated September 2018). Despite this, the inspector found that there was comprehensive review of incidents which had occurred which involved detailed analysis exercises on a regular basis. Overall, there remained very high levels of incidents occurring in the centre and the inspector found that the

registered provider had not taken appropriate action in a timely manner to address this trend and to provide a safer service for residents.

A review of fire precaution measures was completed by the inspector. There was a fire alarm and detection system installed, however, in one unit of the centre there was insufficient detectors in place. There was an absence of emergency lighting in some areas of all three units of the centre. In addition, the inspector found that there were ineffective fire containment measures in place through an absence of fire doors in some areas, the absence of self-closing mechanisms on fire doors, or self-closing mechanisms not being in working order. Fire exits were found to be clear of obstructions and both staff members and residents were aware of the procedures to follow in the event of a fire. There were regular fire drills completed and all residents had clear personal emergency evacuation plans in place.

The inspector reviewed the arrangements for supporting residents with behaviours of distress. The inspector identified three residents who required supports in this area and found that two had detailed plans in place. In the case of a third resident, the inspector found that they were awaiting input from allied health professionals who had scheduled the introduction of a multi-elemental behaviour support plan. While there was evidence of improvement in the area of behaviour support since the time of the last inspection, the inspector found that some concerns remained due to the significant number of incidents which were occurring in the centre and the impact these were having on the well being of residents. For example, in one unit of the centre a resident experienced 89 abusive incidents to date in 2019 as a result of the registered provider's failure to appropriately support other residents with their behaviours of distress. Compounding factors included some members of staff not completing training or refresher training in the area of behaviour support and, as previously mentioned, the high numbers of relief staff members employed in the centre.

A review of measures for safeguarding and protecting residents was completed by the inspector. It was found that the registered provider failed to protect residents from experiencing abuse while availing of the services of the centre. While the incidents occurring were found to be in lower risk categories and to have limited impact during their isolated occurrences, the numbers of incidents were found to be significant. For example, at least 177 incidents were recorded to date in 2019 which involved residents experiencing abuse. Examples of the incidents which took place include aggressive behaviour, shouting and the use of insulting language towards residents which were a consequence of behaviours of distress of other residents. This matter had been identified during a risk based inspection of the centre in June 2019 and while the registered provider had formulated a plan to address this matter, it had not been implemented at the time of this announced follow up inspection.

While reviewing how the rights of residents were protected in the centre, the inspector found that registered provider had failed to ensure that the dignity of residents was respected at all times. As a result of the frequency and significant number of safeguarding incidents experienced by residents, the inspector found that there was limited freedom for exercising choice and control in their daily lives. There

were clear examples in the centre of the privacy and dignity of residents being impacted on a regular basis and effecting residents' personal and living space, personal communications and relationships.

Regulation 10: Communication

Residents were found to have been supported in creative ways to ensure they had accessible, tailored and inclusive methods of communicating which prevented social isolation.

Judgment: Compliant

Regulation 11: Visits

The inspector found that visits to the centre were facilitated and did not impact negatively on other residents availing of the service.

Judgment: Compliant

Regulation 13: General welfare and development

Some residents were not provided with appropriate care and support and as a result did not experience a good quality of life in the centre.

Judgment: Not compliant

Regulation 17: Premises

A shower in the en-suite of one resident's bedroom was not in working order at the time of the inspection.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' food and nutritional needs were found to have been assessed and personal plans were in place for residents and implemented in practice.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector found that there were two areas identified as being required by the regulations which were not outlined in the centre's risk management policy. These were:

- the arrangements for the identification, recording, and investigation of, and learning from, serious incidents or adverse events involving residents and
- the arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

In addition, the registered provider was found to have failed to ensure that there were appropriate systems in place for the assessment and management of risk in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspector found that there were insufficient smoke and fire detectors in place in one unit of the centre and an absence of emergency lighting in some areas of all three units. Concerns were identified in the area of fire containment also with an absence of fire doors in some areas and an absence of self-closing mechanisms in some cases where there were fire doors. In addition, in some cases where there were self-closing mechanisms fitted, these were found not to be in full working order.

Judgment: Not compliant

Regulation 7: Positive behavioural support

While the registered provider had made improvements in the area of positive behavioural supports since the time of the last inspection, the inspector found that concerns remained due to the significant number of incidents which were occurring

in the centre.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that the registered provider failed to ensure that all residents were protected from experiencing abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

Some residents were found to have limited freedom in exercising choice and control over their daily lives due to the ongoing and significant numbers of incidents of a safeguarding nature which they experienced. In addition, the inspector found that the registered provider had not ensured that the centre was operated in a manner which respected the disabilities which some residents experience. These matters were found to negatively impact on the privacy and dignity of residents.

Judgment: Not 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 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glasthule OSV-0004136

Inspection ID: MON-0022568

Date of inspection: 11/09/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The remit of the Person in Charge will be reviewed and changed accordingly. 31/01/2020	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Vacancy (0.5) on one unit has been filled as of 25/10/2019. Staff member (relief panel) has been assigned solely to one unit to cover leave/where additional staffing requirements as of 16/09/2019. Staff member will be assigned to the Designated Centre for the covering of leave or where additional staffing requirements arise. 31/01/2020	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

All staff members identified as requiring mandatory training have been scheduled and will have completed same by 31/01/2020.

Supervision schedule in place and staff will receive supervision in line with organizational policy requirements regarding frequency. 31/12/2019

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Personal and compatibility profiles have been completed for residents who's assessed needs are not being met in full in this location. This has included input from Multi-Disciplinary Team members. 02/08/2019

Document: Transition plan for Service due to incompatibility issues across four residences/ 3 Designated Centers (as provided to inspector on 12/09/2019) will be implemented. Two of the identified residences are in the Glasthule DC. This plan is a phased plan and requires the previous phase to occur before proceeding to the next phase.
Phase 2 of this plan is related directly to one of the houses in the Glasthule DC, it is foreseen that this phase will be completed by 20 12 2019.
Phase 3 of this plan will be completed by 14 02 2020, in line with and responding to the residents individual care and support needs. This phase is directly related to the incompatibility issues in the other house in the Glasthule DC
Full completion: 14 02 2019

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Document: Transition plan for Service due to incompatibility issues across four residences/ 3 Designated Centers (as provided to inspector on 12/09/2019) will be implemented. Two of the identified residences are in the Glasthule DC. This plan is a phased plan and requires the previous phase to occur before proceeding to the next phase.
Phase 2 of this plan is related directly to one of the houses in the Glasthule DC, it is foreseen that this phase will be completed by 20 12 2019.
Phase 3 of this plan will be completed by 14 02 2020, in line with and responding to the

residents individual care and support needs. This phase is directly related to the incompatibility issues in the other house in the Glasthule DC Full completion: 14 02 2019

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Personal and compatibility profiles has been completed for residents who's assessed needs are not being met in full in this location. This has included input from Multi-Disciplinary Team members. 02/08/2019

Document: Transition plan for Service due to incompatibility issues across four residences/ 3 Designated Centers (as provided to inspector on 12/09/2019) will be implemented. Two of the identified residences are in the Glasthule DC. This plan is a phased plan and requires the previous phase to occur before proceeding to the next phase.
Phase 2 of this plan is related directly to one of the houses in the Glasthule DC, it is foreseen that this phase will be completed by 20 12 2019.
Phase 3 of this plan will be completed by 14 02 2020, in line with and responding to the residents individual care and support needs. This phase is directly related to the incompatibility issues in the other house in the Glasthule DC
Full completion: 14 02 2019

Recommendations from National Advocacy Service and Human Rights Committee will be implemented in full for all residents accessing these services. 31/12/2019

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The shower at en-suite will be upgraded to full working order. 31/08/2020

Regulation 26: Risk management	Not Compliant

procedures	
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Risk Management Policy is currently under review and will be updated by Programme Quality and Safety. 31/01/2020 Review at location has been completed to further identify risks with the risk assessment process being implemented for the identified risks. 22/10/2019	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire report has been completed for each unit and all works required will be completed in full. 29/02/2020	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Document: Transition plan for Service due to incompatibility issues across four residences/ 3 Designated Centers (as provided to inspector on 12/09/2019) will be implemented. Two of the identified residences are in the Glasthule DC. This plan is a phased plan and requires the previous phase to occur before proceeding to the next phase. Phase 2 of this plan is related directly to one of the houses in the Glasthule DC, it is foreseen that this phase will be completed by 20 12 2019. Phase 3 of this plan will be completed by 14 02 2020, in line with and responding to the residents individual care and support needs. This phase is directly related to the incompatibility issues in the other house in the Glasthule DC Full completion: 14 02 2019	
Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Personal and compatibility profiles has been completed for residents who's assessed needs are not being met in full in this location. This has included input from Multi-Disciplinary Team members. 02/08/2019 Document: Transition plan for Service due to incompatibility issues across four residences/ 3 Designated Centers (as provided to inspector on 12/09/2019) will be implemented. Two of the identified residences are in the Glasthule DC. This plan is a phased plan and requires the previous phase to occur before proceeding to the next phase. Phase 2 of this plan is related directly to one of the houses in the Glasthule DC, it is foreseen that this phase will be completed by 20 12 2019. Phase 3 of this plan will be completed by 14 02 2020, in line with and responding to the residents individual care and support needs. This phase is directly related to the incompatibility issues in the other house in the Glasthule DC Full completion: 14 02 2019	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Personal and compatibility profiles has been completed for residents who's assessed needs are not being met in full in this location. This has included input from Multi-Disciplinary Team members. 02/08/2019 Document: Transition plan for Service due to incompatibility issues across four residences/ 3 Designated Centers (as provided to inspector on 12/09/2019) will be implemented. Two of the identified residences are in the Glasthule DC. This plan is a phased plan and requires the previous phase to occur before proceeding to the next phase. Phase 2 of this plan is related directly to one of the houses in the Glasthule DC, it is foreseen that this phase will be completed by 20 12 2019. Phase 3 of this plan will be completed by 14 02 2020, in line with and responding to the residents individual care and support needs. This phase is directly related to the incompatibility issues in the other house in the Glasthule DC Full completion: 14 02 2019 Recommendations from National Advocacy Service and Human Rights Committee will be implemented in full for all residents accessing these services. 31/12/2019	

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(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	14/02/2020
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	31/01/2020

Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/01/2020
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/01/2020
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	31/01/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/08/2020

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Red	14/02/2020
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	31/01/2020
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	Not Compliant	Orange	31/01/2020

	are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	22/10/2019
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	29/02/2020
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	29/02/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	29/02/2020
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in	Not Compliant	Orange	14/02/2020

	response to a complaint are put in place.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	31/01/2020
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	14/02/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	14/02/2020
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	14/02/2020

Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	14/02/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	14/02/2020