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:	Glencorry
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	13 February 2024
Centre ID:	OSV-0002383
Fieldwork ID:	MON-0042671

About the designated centre

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

Glencorry is a designated centre operated by St. Michael's House. It is located in a campus based service for persons with intellectual disabilities located in North Dublin. The centre comprises of one large building and provides full-time residential services to six persons with intellectual disabilities. The building consists of six resident bedrooms, a large living room, a large dining room, a kitchen and separate pantry space, a staff office, a staff room, a bathroom, a separate shower room, a utility room, and a large entrance hallway. There is an outdoor patio space to the front of the centre with an area for outdoor dining, a seating area, raised planting beds and a water feature. Residents are supported by a person in charge, a clinical nurse manager, staff nurses, social care workers, care workers, a cook, and a household worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 (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
Tuesday 13 February 2024	10:30hrs to 17:30hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out in response to a high number of safeguarding notifications submitted to the Chief Inspector of Social Services.

The purpose of this inspection was to assess the actions being taken by the provider to address the ongoing incompatibility concerns in the centre and to assess if the provider had implemented their compliance plan response from a previous inspection of this centre that had identified non compliance in the areas of safeguarding and residents' rights.

The inspector used observations, in addition to a review of documentation, and conversations with staff and residents to form judgements on the residents' quality of life.

The centre consisted of one residential bungalow situated on a congregated campus setting in North Dublin. The designated centre has a registered capacity for six residents, at the time of the inspection there was no vacancies. The person in charge was present to facilitate the inspection. The service manager was contacted and made themselves available later in the day.

The person in charge accompanied the inspector on a walk around of the centre. Overall, it was found to be clean, bright, homely, nicely furnished, and the lay out was appropriate to the needs of residents living there.

In the hallway of the bungalow, the centre's fire evacuation plan, mission statement and certificate of registration were displayed. The bungalow consisted of a large living area and a separate dining area which was connected to a modest sized kitchen. Each resident had their own bedroom. All the bedrooms were personalised to the resident's tastes with art-work, photos of family and of residents attending events and activities on display.

On the day of the inspection, the provider's maintenance team were on site, hanging up canvas photo portraits of the residents on the wall in the sitting room. They were also fitting a stereo system to the wall of one residents bedroom. These home improvements were demonstrating the person in charge and provider's commitment to ensuring residents had a homely environment that was well-maintained, personalised and homely.

The utility room of the bungalow was appropriately fitted out with a washing machine and dryer. Staff were aware of correct procedures for laundry management and there was further guidance on the wall. The centre had utilised the support of a part-time cleaner, three times a week and they were present on the day of the inspection. The centre also provided residents with a large accessible garden, garden furniture and a gazebo area which was well maintained and a pleasant

space.

The inspector spoke with the person in charge, the service manager, and a social care worker on duty on the day of inspection. They all spoke about the residents warmly and respectfully, and demonstrated a rich understanding of the residents' assessed needs and personalities and demonstrated a commitment to ensuring residents needs were met to a high standard at all times.

However, they had concerns regarding ongoing behavioural incidents and peer-to-peer safeguarding concerns occurring in the centre and the impact these were having on residents.

They outlined to the inspector that peer-to-peer incidents were having a negative impact on the resident group. For example, their mood, sense of safety, and the overall atmosphere in the centre.They told the inspector that they had supported residents to use the provider's complaints policy and procedures to make complaints about the service in an effort to support residents' rights and to try to bring about a resolution to the situation that was ongoing in the centre.

Both the person in charge and the staff member spoke about some resident's changing health needs and the corresponding support interventions they required. The person in charge and staff member were very knowledgeable of the needs of the resident and had recently undertaken specific training in the area of mental health and intellectual disability.

They also spoke about some of the interventions that had been put in place. These included additional staffing, re-configuration of communal areas, higher levels of supervision and activity planning so that residents were kept separate from each other to avoid altercations. While these measures were easing the situation, some of the interventions were restrictive in nature and therefore impacted on residents' rights to freedom and choice in their home.

The person in charge was satisfied with the staff skill-mix and arrangements, and said that residents' needs and rights were being mostly met in the centre. However, they also outlined the current safeguarding concerns posed a risk to the residents' overall well-being. The person in charge told the inspector that the provider was engaging with their funder and external providers to source a more appropriate residential placement for one resident to address the incompatibility issues however, they had not been successful yet.

The inspector met with four of the residents who lived in the centre and observed the interactions between them and staff members. The inspector saw that staff and resident communications were familiar and kind. Staff were observed to be responsive to residents’ requests and assisted residents in a respectful manner. A resident was having breakfast in the dining area when the inspector arrived. Another resident made it known they wished to go out with staff and this was facilitated in a responsive manner by staff in the centre. In the afternoon, when residents returned from their respective day services, there was an Valentine's Day focused activity arranged for residents and staff had taken the time to decorate the dining area of

the house with love hearts and banners for the occasion.

Two residents came and spoke directly to the inspector, they were supported to do this by the person in charge. One resident told the inspector that they did not like living in the centre and wanted to move, when asked what they didn't like, the resident did not elaborate further. Staff informed the inspector in recent months the residents' needs had changed a lot and raised concerns that the centre was not meeting the resident's changed needs in addition, staff told the inspector that the resident made frequent remarks about wishing to move from the centre.

The second resident told the inspector, they liked living in the centre and was looked after well by staff. The person in charge supported this resident to talk to the inspector about a recent complaint she had made. The resident was unable to verbalise her concerns but the inspector later reviewed it in the complaints log to gather further information in this regard.

From what the inspector observed, read, and were told, it was clear that the residents, for the most part, had active and rich lives. However, the incompatibility issues and ongoing safeguarding concerns were adversely impacting on the quality and safety of the service.

The next two sections of the report presents the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The provider had put in place comprehensive governance and oversight arrangements to monitor the quality and safety of care and support in the centre. The provider was well informed and knowledgeable of the ongoing incompatibility issues in the centre and were making concerted efforts and arrangements to respond to and mitigate the incidents occurring and provide an enhanced supervision and support arrangement for some residents. However, some improvement was required in this regard.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge had a good understanding of their role and responsibilities and of the supports required to meet the assessed needs of the residents in the centre. The person in charge reported to a service manager who in turn reported to a director of care, and there were effective systems for the management team to communicate and escalate any issues.

The staffing arrangements in the centre, including staffing levels, skill mix and qualifications, were effective in meeting most of the residents' assessed needs.

There was a planned and actual roster maintained by the person in charge. Staffing arrangements took into consideration any changing or emerging needs of residents and endeavoured to facilitate continuity of care. However, staff vacancies and the current resident incompatibility issues within the centre were impacting on the quality of care and support in the centre.

Staff had completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge provided support and formal supervision to staff working in the centre.

The provider had identified that there were compatibility issues within the centre. The safeguarding issues had been escalated and reported in line with the provider's safeguarding policy. Safeguarding guidelines and plans had been drawn up and were reviewed and updated as required.

However, despite these arrangements, safeguarding plans were not fully effective and residents were experiencing potential institutional abuse due to the peer-to-peer confrontations and safeguarding incidents they were experiencing on an ongoing and regular basis. The provider was consulting with residents, their families, staff, and external agencies in order to develop a more long term plan to address the incompatibility issues and ensure all residents were provided with a service that could meet their assessed needs.

Through a review of notifications, documents, and discussion with staff it was found that residents' quality of life was significantly impacted by the behaviour presentation of a peer living in the centre. There had been a substantial number of adverse incidents recorded including incidents of verbal abuse, physical threats, and instances whereby a resident's behaviour prevented another resident from accessing communal areas of their home which impacted on their rights regarding activity and recreation.

Staff had implemented a number of safeguarding measures in an attempt to minimise the negative impact of the ongoing incompatibility issues. It was found that activities and staffing requirements had to be navigated to reduce the risk of compatibility related behavioural incidents occurring in the house.

Notwithstanding these described issues, the inspector found that the person in charge and staff were endeavouring to ensure that the well-being and welfare of residents living in the centre was maintained by a good standard of evidence based care. Residents were supported by a team of nurses, social care workers and direct support workers. As previously mentioned staffing arrangements had been increased in number in response to safeguarding concerns.

Residents appeared comfortable in each staff members' company and were seen to communicate their needs and preferences to the staff supporting them. There were a number of familiar staff members employed in the centre who provided good continuity of care for all its residents. In order to provide the additional staff support required to implement safeguarding plans there were some shifts covered by the

providers own relief staff and/or agency staff.

An up-to-date statement of purpose was in place which met the requirements of the regulations and accurately described the services provided in the designated centre at this time.

A directory of residents was made available to the inspector on the day of inspection, and was found to be accurate and up to date.

The registered provider had established an effective complaints procedure for residents and their representatives to utilise as required by the regulations. The procedure was an easy-to-read format and underpinned by a comprehensive policy. Complaints made by residents had been managed appropriately.

This inspection found, despite initiatives and efforts on the part of the provider and person in charge to respond to and manage the ongoing incompatibility issues in the centre, arrangements remained overall ineffective in ensuring all residents were experiencing a service that could meet their needs and ensure good safeguarding arrangements.

Regulation 15: Staffing

The qualifications and skill mix of staff were appropriate to the number and assessed needs of the residents. The provider had responded to residents' changing needs by increasing the whole time equivalent of staff to provide an individualised service with the support of two staff to one resident who required this. The additional hours were being funded by the provider.

However, the centre was operating with two whole time equivalent vacancies at the time of the inspection. These positions and the additional hours were required to manage the presenting safeguarding concerns were filled, by a panel of regular relief and agency staff which somewhat supported continuity of care for residents. However there were times when this was not possible.

The inspector was informed that permanent staff shared the role of providing one-to-one supervision for one resident who required additional supports as per their behaviour support plan. This was to provide familiar, consistent care to this resident and in turn to support the centre to manage behavioural incidents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs and to ensure that

adequate training levels were maintained. All staff have completed mandatory training including refreshers when required.

The inspector found that staff were receiving regular supervision as appropriate to their role. Supervision records reviewed were in line with organisation policy, with a provision for staff to request early supervision if they have any concerns arising.

Additional training around mental health had commenced for two staff to provide additional support for one particular residents changing needs.

Judgment: Compliant

Regulation 19: Directory of residents

The centre had an up to date directory of residents and it was made available to the inspector to view and met the requirements of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined governance structure which identified the lines of authority and accountability within the centre and ensured the delivery of good quality care and support that was routinely monitored and evaluated.

It was evidenced that there was regular oversight and monitoring of the care and support provided in the designated centre and there was regular management presence within the centre. The staff team was led by an appointed person in charge. The person in charge reported to a service manager. They also held monthly meetings which reviewed the quality of care in the centre.

A review of staff meetings showed regular discussions on safeguarding, training, general housekeeping, medication, restrictive practices, residents and staffing.

There was a comprehensive auditing system in place by the person in charge to evaluate and improve the provision of service and to achieve better outcomes for residents. Provider audits and unannounced visits were also taking place to ensure that service delivery was safe and that a good quality service was provided to residents. These monitoring systems had identified a trend of incidents between residents and there was a proactive approach to addressing the issue.

The provider had identified that the service was not meeting the assessed needs of all residents living in the centre. While the provider was endeavouring to meet the health, personal and social are needs of all residents, not all residents accepted the

supports in place. This is discussed further in regulation 5.

Despite initiatives and efforts on the part of the provider and person in charge to respond to and manage the ongoing incompatibility issues in the centre, arrangements remained overall ineffective in ensuring all residents were experiencing a service that could meet their needs and ensure good safeguarding arrangements.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place which met the requirements of Schedule 1, and clearly set out the services provided in the centre and the governance and staffing arrangements.

A copy of the statement of purpose was readily available to the inspector on the day of inspection. It was also available to residents and their representatives.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had established an effective complaints procedure underpinned by a comprehensive policy. The complaints procedure was in an easy-to-read format and accessible to residents. Complaints were regularly discussed at resident meetings to promote awareness and understanding of the procedures.

The inspector found that complaints made by residents and their representatives had been recorded and managed appropriately in line with the provider's policy. The inspector reviewed a sample of these logs and found that complaints were being responded to and managed locally.

The person in charge was aware of all complaints and they were followed up and resolved in a timely manner, where possible.

Due to ongoing complaints from residents regarding safeguarding, the person in charge has linked with the providers own quality department for support to resolve complaints and the person in charge meets with each complainant on monthly basis to provide an update.

Notwithstanding, there were two compliments noted in the sample reviewed, both were from family members and in relation to the quality of care provided for their

loved ones.

Judgment: Compliant

Quality and safety

The findings from this inspection demonstrated residents' well-being and welfare were supported by a good standard of evidence-based care and support, for the most part. However, not all residents' assessed needs could be met in the centre and and this was having a negative impact on the quality and safety of service provided to them and their peers.

The governance and management arrangements in the centre did not fully support the provision of safe and quality care. While there were a number of good practices observed at a local level in the centre, the quality of care was significantly impacted by ongoing safeguarding issues that were attributable to resident incompatibility. The inspector found that although the provider had implemented strategies to reduce the compatibility issues in the house, the overall impact of the incidents was effecting the residents' lives in a negative manner.

The premises was well maintained throughout. There was adequate private and communal spaces and residents had their own bedrooms, which were being decorated in line with their tastes. However, due to the ongoing safeguarding concerns, environmental restrictive practices, that had been put in place to reduce safeguarding incidents, were in turn impacting on residents being able to fully enjoy all areas of their home.

There was a comprehensive assessment of need in place for each resident, which identified their health care, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness. However, while residents needs had been assessed, the changing needs of one resident meant that the centre was no longer able to cater and support their care needs and a suitable alternative living arrangement that could had not yet been sourced.

Positive behaviour support plans were in place for residents where required. The plans were up-to-date and readily available for staff to follow. In addition, staff had also completed training in positive behaviour support to ensure they were skilled and knowledgeable in how to respond to behaviours of concern and implement behaviour support recommendations and plans.

There were arrangements, underpinned by robust policies and procedures, for the safeguarding of residents from abuse. Staff working in the centre completed training to support them in preventing, detecting, and responding to safeguarding concerns. Staff spoken with were familiar with the content of the plans and the procedure for reporting any concerns. However, there were ongoing safeguarding incidents in the

centre attributable to the incompatibility of residents.

These incidents were reported and screened, and safeguarding plans were developed as required. The provider had taken actions to respond to the safeguarding issues in the centre by providing additional staffing and multidisciplinary allied professional input. The provider had also commenced a consultation with multi-disciplinary clinicians and external agencies with a view to developing a more effective longer term plan.

Despite these efforts by the provider, there remained ongoing safeguarding risks in this centre. Residents regularly experienced verbal abuse, witnessed verbal altercations and threats of aggression, and were restricted in accessing some parts of their home or receiving care due to the behaviour of others.

While the provider had good arrangements for managing safeguarding concerns such as multidisciplinary team input, staff training, and development of safeguarding plans, the residual risk to residents' safety remained, and required mitigation to ensure residents were sufficiently protected from abuse in the centre.

While residents' day-to-day experiences in their home were not optimal, it was found that the person in charge and staff members endeavoured as much as possible to support residents to exercise their rights. However, due to the nature of the incidents and their frequency environmental restrictions in place meant that not all residents had the freedom to exercise choice and control over their daily life.

The inspector found that the quality and safety of the service provided in the centre to residents was significantly compromised due to deficits and risks in relation to the assessment and meeting of residents' full needs, positive behaviour support, safeguarding and resident's rights.

Regulation 17: Premises

Overall, the premises was homely and suitable to meet the assessed needs of residents.

The registered provider had made provision for the matters as set out in Schedule 6 of the regulations.

Residents had their own bedrooms which were decorated in accordance with their personal tastes. There was adequate private and communal accommodation for the residents, including a sitting room and a kitchen/dining area and spacious garden area.

Residents spoken with told inspectors that they were happy with their home with regards to the premises and layout.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured assessments of residents' needs were completed and informed the development of personal plans. The inspector reviewed a sample of residents' assessments and plans.There was a comprehensive assessment of need in place for each resident, which identified their healthcare, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness.

However, the provider had not ensured that the appropriate arrangements were in place to meet the needs of one resident. They had identified that the centre was not fully suitable to meet all residents' assessed needs, particularly in relation to the required living arrangements for one resident and their incompatibility with other residents, which was resulting in ongoing safeguarding concerns.

Due to this residents changing needs and declining mental health, the support plans in place were not sufficient in meeting their personal and social needs and as a result the inspector was not assured that the centre was suitable for the purpose of meeting their assessed needs or that there was adequate arrangements in place to meet their needs.

The provider and person in charge were currently engaged with their funder and reviewing their own internal resources to source more suitable accommodation, however had not yet been successful and this was impacting on the quality and safety of service provided to all its residents.

They remained committed to sourcing appropriate accommodation both internally and externally, and were utilising additional resources such as increased staffing and multidisciplinary team services.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The person in charge had ensured, where residents required positive behaviour support, appropriate and comprehensive arrangements were in place.

Clearly documented de-escalation strategies were incorporated as part of residents' behaviour support planning with accompanying well-being and mental health support plans.

All staff had completed positive behaviour support training.

Restrictive practices were regularly reviewed with clinical guidance and risk assessed to use the least restrictive option possible.

However, the environmental restrictions that were put in place to mitigate and manage safeguarding concerns, were impacting on residents rights, this will be discussed further in Regulation 9: Residents' Rights.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented measures to protect residents from abuse, which were underpinned by comprehensive safeguarding policies and procedures.

Staff completed training in safeguarding residents, and they could describe the arrangements for inspector.

Safeguarding concerns had been reported, responded to, and managed in line with the provider's policy. However, there was ongoing safeguarding concerns in the centre. Concerns for residents' safety were noted in the provider's internal audits, management meeting minutes, and reports from multidisciplinary team services. Safeguarding was also a regular topic discussed at team meetings.

Recent safeguarding concerns had been reported, responded to, and managed in line with the provider's policy. Safeguarding plans had been developed and were readily available for staff to refer to. However, staff spoke about the limited effectiveness of the safeguarding plans, and the challenges they faced in ensuring residents' safety and promoting residents rights. Therefore, the overall effectiveness of the safeguarding plans and associated interventions is limited and residents continued to be at risk of abuse until the incompatibility issues are fully resolved.

The provider had responded to the safeguarding concerns with increased staffing levels and development of personal plans. Safeguarding was also discussed at residents meetings to promote their understanding, and residents had also been supported to avail of the providers complaints procedure.

The provider was also endeavouring to source more appropriate accommodation for one resident to address the incompatibility issues. However, the effectiveness of the safeguarding arrangements and promptness in addressing the concerns were not sufficient.There was also ongoing support and guidance from the provider's safeguarding team.

The inspector found that although the provider was endeavouring to manage and implement strategies to reduce the compatibility issues in the house, the overall

impact of the incidents was affecting residents' lives in a negative manner.

Without further intervention, the inspector could not be assured that residents were protected from all forms of abuse at all times. Residents are still at risk and their quality of life is being impacted upon in their own home.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had ensured that the centre was operated in a manner that ensured residents had participated and consented to decisions about their care and support.

Residents rights were discussed regularly at residents meetings and a rights awareness checklist and human rights support plan was available in each residents personal plan.

Residents were supported to use the provider's complaints policy and procedures and put their complaints in writing to the provider.

However, despite these rights-based arrangements and systems, residents continued to experience verbal abuse, witness verbal altercations and threats of aggression, and were restricted in accessing some parts of their home due to the behaviour support needs of others.

To mitigate and manage the ongoing safeguarding concerns in the centre, environmental restrictions in the communal areas were in place. These restrictions were implemented to ensure residents did not interact with each other and a distance was maintained. While these initiatives were somewhat effective, the arrangement was impinging on residents' rights to exercise choice, freedom and control in their daily lives.

Furthermore, complaints from service-users regarding safeguarding, albeit managed appropriately and in line with the provider's complaints policy and procedures, remained unresolved. Complaints demonstrated a consistent theme relating to residents rights regarding their privacy and living space and ultimately the right to peace in their own home.

Residents no longer wanted to live with each other and due to the nature of the incidents and their frequency demonstrating the implementation of a rights-based approach to care was proving challenging in the centre and improvements were required.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glencorry OSV-0002383

Inspection ID: MON-0042671

Date of inspection: 13/02/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • New Staff Nurse started in in Glencorry on 02/04/2024 to back fill one of the vacancies. • The PIC will block book regular agency staff to provide continuity for DSMAT hours and hours left vacant by staff on reduced hours. • The PIC completes and manages the roster within the centre based on residents assessed needs within the approved whole time equivalent. The roster is reviewed by the service manager to ensure that there is an appropriate skill mix of staff daily. • The registered provider will continue to recruit for all frontline vacancies (in line with HSE derogation process). Vacancies for the identified centre are on the organisational recruitment spreadsheet which is managed by HR and the Service Area Administration Manager.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Director of Adult Services will consult the with Principal Psychologist to explore the possibility of completing an Enhanced ME-plan for one resident with complex needs. • The registered provider has approved the block booking of agency staff to provide continuity for DSMAT hours and hours left vacant by staff on reduced hours. • A meeting has been scheduled with the HSE safeguarding team to discuss the on-going safeguarding issues in Glencorry. The meeting has been scheduled for 09/04/2024. • The Registered Provider will review, amend and update the Business case for resubmission to the HSE for the identified resident with revised risk assessments • There is a comprehensive safeguarding risk assessment in place, and this is logged on	

the centres risk register.
• The registered provider will continue to recruit for all frontline vacancies (in line with HSE derogation process).

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The Director of Adult Services will consult the with Principal Psychologist to explore the possibility of completing an Enhanced ME-plan for one resident with complex needs.
• The PIC will request a full review of the identified residents Positive Behavioural Support plan and schedule a specific team meeting in the implementation of the plan in keeping everyone safe in the centre.
• The Registered Provider will review, amend and update the Business case for resubmission to the HSE for the identified resident with revised risk assessments.
• The Registered Provider will continue to review and explore all existing residential vacancies in line with the resident's assessed needs and ongoing support requirements.
• The PIC ensures that all residents Assessment of Needs are reviewed annually or more often if required.
• The PIC ensures that all residents support plans are reviewed quarterly, and amendments made as needed.
The Director of Adult Service will advise St Michaels CEO of the Cautionary meeting held on the 25th of March 2024 and the possible consequences of continued non-compliance within the centres. Reference will be noted to Regulation 5: Individual assessment and personal plan. Date to be achieved 05.04.2024.
The Registered Provider will also advise the HSE of the cautionary meeting and the possible consequences of continued non-compliance within the centre including:
• Issuing of a written warning
• Application of a restrictive condition to the registration of the centre
• Issuing of a notice of proposal to cancel Registration
Date to be achieved: 30.04.2024
The Registered Provider will review, amend and update the Business case for resubmission to the HSE for the identified resident with revised risk assessments. Date to be achieved: 06.05.2024
The Registered Provider will continue to review and explore all existing residential vacancies in line with the resident's assessed needs and ongoing support requirements. St Michaels House Residential approvals committee meet monthly, and the identified resident profile will be submitted in assessing any potential vacancies across the service areas in meeting their assessed needs.
Date to be achieved: 30.12.2024.
The Director of Estates and his team will complete a review of all existing St Michaels House properties and identify if there is capacity within these centres for development in meeting the assessed needs of the identified resident. Date to be achieved: 30.6.2024.

The Registered Provider will ensure the assessed needs of the other residents are considered in any potential proposal being developed. Date to be achieved: 30.6.2024
The Registered Provider in consultation with the Director of Estates will continue to explore external properties within the resident's community and support network, with the intentions of submitting an application to register the property as a designated centre, should a suitable location be identified. Date to be achieved: 30.12.2024
The Registered Provider will develop a business proposal for the HSE in the opening of a new residential service with the aim of creating additional residential placement for a service user within St Michaels House residential wait list.
Costings will include rental, staffing or where applicable possible costings for the development of existing properties. All developments will be subject to statutory requirements. Date to be achieved: 30.5.2024
The Registered Provider will raise any new proposal with the HSE at SMH Operational meetings which are held quarterly.
Next meeting scheduled on the 30.4.2024
Glencorry non-compliance will be raised when these meetings occur and escalated as required. Date to be achieved: 30.04.2024
The Person in Charge will review all the resident's assessment of needs and support plans within the centre. Date to be achieved:- 30.6.2024.
The identified residents MDT will continue to engage with safeguarding team in the HSE to assess the effectiveness of Compatibility assessment tool and agreed supports Date to be achieved: 31.12.2024
The Director of Adult Services will consult with the Principal Psychologist to explore the possibility of completing an Enhanced ME-plan for one resident with complex needs. Date to be achieved: 31.10.2024

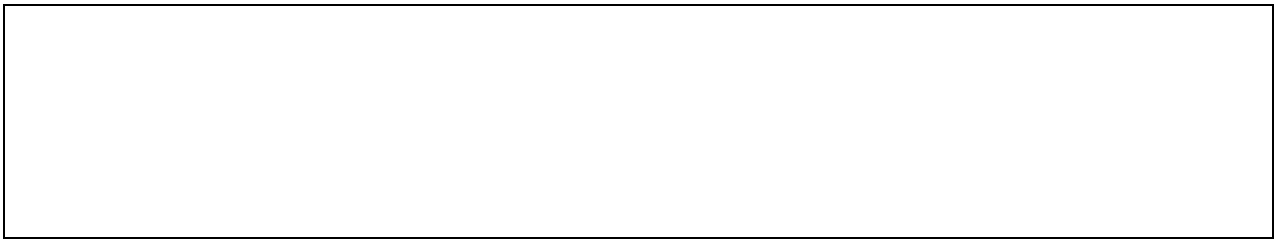
Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Director of Adult Services will consult with the Principal Psychologist to explore the possibility of completing an Enhanced ME-plan for one resident with complex needs
• An unfunded DSMAT is in place in the centre to provide additional staffing daily to ensure that residents needs are met in line with their assessed needs and relevant risk assessments.
• The Registered Provider will review, amend and update the Business case for resubmission to the HSE for the identified resident with revised risk assessments.
• A meeting has been scheduled with the HSE safeguarding team to discuss the on-going safeguarding issues in Glencorry. The meeting has been scheduled for 09/04/2024.
• All potential safeguarding incidents are reported and screened by the principle social worker in line with national and SMH policy and legislation.
• There is a safeguarding plan in place for all residents which is reviewed and updated as required.
• The Director of Adult Services will commission a compatibility assessment for the designated centre. The Designated Officer will lead out on the assessment' and this will

remain open until the compatibility issues are resolved.
• The PIC will request a full review of the identified residents Positive Behavioural Support plan and schedule a specific team meeting in the implementation of the plan in keeping everyone safe in the centre.
• The person causing concern and the staff team has regular clinical input from the MHID team, psychiatrist, and psychologist.
• Clinical supports are available to all residents who require support following a safeguarding incident.
• All residents are supported to make a complaint through the SMH complaints process if they have been impacted by a safeguarding incident.
• There is a comprehensive safeguarding risk assessment in place, and this is logged on the centres risk register.
• The Director of Adult Services continues to raise safeguarding concerns with regards to Glencorry at quarterly operational meetings with the HSE.
• Staff have applied to the national advocacy service for an external advocate for each resident.
The Director of Adult Service will advise St Michaels CEO of the Cautionary meeting held on the 25th of March 2024 and the possible consequences of continued non-compliance within the centres. Reference will be noted to Regulation 8: Protection
Date to be achieved: 05.04.2024.
The Registered Provider will also advise the HSE of the cautionary meeting and the possible consequences of continued non-compliance within the centre including:
• Issuing of a written warning
• Application of a restrictive condition to the registration of the centre
• Issuing of a notice of proposal to cancel Registration
Date to be achieved: 30.04.2024
The Registered Provider will review, amend and update the Business case for resubmission to the HSE for the identified resident with revised risk assessments. Date to be achieved: 30.04.2024
The Registered Provider will continue to provide additional supports to the residents within the centre and maintain the identified residents supports that are currently in place. Date to be achieved: 04.04.2024.
The PIC will continue to schedule regularly MDT meetings for the residents within the centre as required. Date to be achieved: 01.06.2024.
The PIC will continue to work closely with St Michaels House Designated Officer and the SMH Safeguarding team and schedule regularly reviews to ensure all residents within the centre have up to date safeguarding plans in place. Date to be achieved: 01.05.2024.
The PIC will continue to notify and submit NF06 and PSF's as required. Date to be achieved: 04.04.2024.
The PIC will request a full review of the identified residents Positive Behavioural Support plan and schedule a specific team meeting in the implementation of the plan in keeping everyone safe in the centre. Date to be achieved: 01.06.2024.
As identified in Regulation 5, the Registered Provider will continue to explore all internal and external residential options for the identified resident. Date to be achieved: 30.12.2024.
The Director of Adult Services will consult with the Principal Psychologist to explore the possibility of completing an Enhanced ME-plan for one resident with complex needs. Date to be achieved: 31.10.2024

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Director of Adult Services will consult with the Principal Psychologist to explore the possibility of completing an Enhanced ME-plan for one resident with complex needs
• The Registered Provider will review, amend and update the Business case for resubmission to the HSE for the identified resident with revised risk assessments
• Staff have completed The Fundamentals of Advocacy in Health and Social Care.
• Staff have completed or are wait listed for Strengthening Rights training.
• Restrictive practices are reviewed regularly by PIC and discussed at staff meetings in line with SMH restrictive practice policy.
• The PIC and staff team ensure that the residents can exercise choice and control in their daily life through their personal plans and weekly residents' meetings.
• All residents are supported to make a complaint through the SMH complaints process if their rights have been impacted.
• All residents have a rights support plan which is reviewed quarterly by key workers and the PIC or more often if needed.
• Staff have applied to the national advocacy service for an external advocate for each resident.
The Director of Adult Service will advise St Michaels CEO of the Cautionary meeting held on the 25th of March 2024 and the possible consequences of continued non-compliance within the centres.. Reference will be noted to Regulation 9: Residents Rights.
Date to be achieved: 05.04.2024.
The Registered Provider will also advise the HSE of the cautionary meeting and the possible consequences of continued non-compliance within the centre including:
• Issuing of a written warning
• Application of a restrictive condition to the registration of the centre
• Issuing of a notice of proposal to cancel Registration.
Date to be achieved: 30.04.2024
The Person in Charge will review all the resident's assessment of needs and support plans within the centre and in particular in relation to residents' rights. Date to be achieved; 01.05.2024
The PIC will make an application to the National Advocacy service on behalf of the residents within the centre, where their rights are being infringed upon by the identified residents. Date to be achieved: 01.05.2024.
PIC will ensure that residents rights within the centre are discussed at resident forums and residents will be supported to make complaints as required. Date to be achieved: 01.05.2024.
As identified in Regulation 5 & 8 above, the Registered Provider will continue to explore all internal and external residential options for the identified resident and in meeting all residents needs in relation to Regulation 9. Date to be achieved: 30.12.2024.
The Director of Adult Services will consult with the Principal Psychologist to explore the possibility of completing an Enhanced ME-plan for one resident with complex needs. Date to be achieved: 31.10.2024



Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2024
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.	Substantially Compliant	Yellow	31/12/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/12/2024

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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).	Not Compliant	Orange	31/12/2024
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2024
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	Not Compliant	Orange	31/12/2024

	or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/12/2024