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:	James Connolly Memorial Residential Unit
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	29 June 2022
Centre ID:	OSV-0002502
Fieldwork ID:	MON-0036896

About the designated centre

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

James Connolly Memorial Residential Unit is a congregated setting proving care and support to 12 adults with disabilities (both male and female) in Co. Donegal. The premises consist of a large two storey building and is institutional in design. Communal facilities include two large sleeping dormitories (where female residents sleep in one dormitory and male residents sleep in the other). There are also single occupancy bedrooms. All bedroom facilities are on the ground floor of the centre. The ground floor also has a large bright sitting/TV room, multiple bathroom/restroom facilities, a relaxation/sensory area, dining rooms and a small kitchenette which is available for residents to use. There is also a larger industrial-style kitchen on the ground floor (not accessible to the residents) that provides meals at specific times throughout the day to residents. The second floor of the building has facilities for management and staff of the centre including offices, a kitchen, a staff dining area and staff restroom. The centre is located on a site from which a range of other Health Service Executive (HSE) services are accommodated. The building is surrounded by gardens and grounds that are well-maintained and private parking facilities are also available. The centre is staffed on a 24/7 basis with a full time person in charge (who is a clinical nurse manager II), a team of staff nurses and health care assistants. Access to GP services and other allied healthcare professionals form part of the service provided to the residents. Transport is also provided for residents for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Wednesday 29 June 2022	09:00hrs to 17:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This centre is run by the Health Service Executive (HSE) in Community Healthcare Organisation Area 1 (CHO1). Due to concerns about the management of safeguarding concerns and overall governance and oversight of HSE centres in Co. Donegal, the Chief Inspector undertook a review of all HSE centres in that county. This included a targeted inspection programme which took place over two weeks in January 2022 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection) and regulation 23 (Governance and management). The overview report of this review has been published on the Health Information and Quality Authority (HIQA) website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Donegal.

At the time of inspection, the provider had started to implement a number of actions to strengthen the governance and management arrangements in this designated centre. These will be discussed later in this report.

This centre was a congregated setting and institutional in design. It was a large two-storey building with residents' living quarters on the ground floor and a staff canteen and administrative offices upstairs. The living quarters comprised of two communal sleeping dormitories, one for male and one for female residents, and some single occupancy bedrooms. Facilities for bathing and showering were provided. There was a large dining room and a kitchen where a professional catering service was provided. There was a smaller kitchen and dining area next door for residents to use when the main kitchen was closed. Towards the front of the building there was a large sitting area, where a television was playing music. There was an activity room and a multi-sensory room close by.

Although the centre was institutional in presentation, the inspector saw that efforts were made to ensure that the environment was as homely as possible. During the last inspection, areas requiring further improvement were highlighted. These included repair and replacement of floor coverings and upgrading of bath and shower rooms. These works were nearing completion. In the longer term, the provider had a plan in place for residents to move from this congregated setting to homes in the community. This will be expanded on below.

Although day services had reopened the person in charge told the inspector that residents from this designated centre were not attending. Therefore, all residents were at the designated centre on the day of inspection. The staff on duty told the inspector that some residents had visits from their family members and these visits

were facilitated and supported by staff.

On the day of inspection, most residents were in the day room. They did not communicate with the inspector. Some residents were observed sitting in wheelchairs while listening to music. Others were lying on the couches provided. One resident was taking part in a sensory programme with a staff member. Another resident was having a hand massage. One resident was in bed. Later that morning, the inspector observed a resident having a coffee break in the smaller kitchen. The inspector spoke with the resident and they smiled from time to time. It was evident that the staff providing support knew the resident and their wishes well and were attending to them promptly. At lunchtime, the inspector spent some time in the main dining room. The residents were sitting in the room together but at different tables. Each resident had a food diary which was used to record their meals. The inspector saw that the food was freshly cooked, nicely presented and in accordance with residents dietary plans. There was an easy-to-read picture menu on the notice board and it was an accurate reflection of what was served on the day. After lunch, the staff on duty told the inspector that the some residents would go for a drive on the bus.

The residents in this designated centre had a range of physical, sensory and medical conditions and had high support needs. The inspector saw that the staff were very busy ensuring that the residents were supported. Those spoken with were knowledgeable on the needs of residents and were respectful when speaking about them. Some staff told the inspector that they were redeployed from day services or were new to the service. This meant that it was difficult to provide a consistent staff team and this will be expanded on later in this report.

The next two sections present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to the resident.

Capacity and capability

As outlined above, this inspection was carried out to monitor compliance with the regulations and to review the provider's actions from the targeted inspections completed in January 2022. The inspector found that there was a good management structure in place in this centre and some good monitoring arrangements. However, improvements were required in a number of key areas including staffing arrangements, the premises provided, infection prevention and control measures used and governance, management and oversight.

The person in charge worked full-time in this designated centre. They told the inspector about the actions that had commenced as part of the provider's compliance plan from the recent overview report. These included centre level staff

governance meetings which were taking place regularly. Staff spoken with told the inspector that they found these meetings helpful and supportive. However, due to significant staffing issues, at a recent meeting, it was noted that only two of the 11 staff in attendance were regular core staff members. The remaining attendees were redeployed staff, new staff or agency staff.

Bi-monthly meetings between the area coordinator and the person in charge had commenced. The person in charge told the inspector that they had attended one meeting to date and that another was planned. The policy, procedure, protocol and guidelines development group (PPPG) was described as running again and one meeting had taken place to date. At network level, the quality safety service improvement governance group had held one meeting and the person in charge told the inspector that the terms of reference for the work of this group were agreed. A plan was in place for the safeguarding review group to meet but this had not commenced at the time of inspection.

A review of the audits used in centres across the county was due to be completed. On the day of inspection, the person in charge was not familiar with the plan in place to progress this work. However, a plan was in place to provide support and training in relation to the completion of annual reviews and six monthly visits. Furthermore, a workshop for persons in charge was planned and a date was agreed.

An up-to-date statement of purpose was available for review and it contained the information required under Schedule 1 of the care and support regulations. There was evidence of regular review and updating for example, changes to the information in relation to COVID-19 guidelines and updating of information in relation to the certificate of registration. The provider had a range of policies, procedures and guidelines which were available and accessible for staff's use. A sample of policies were reviewed and some were found to be out of date. As referred to above, the person in charge told the inspector that the PPPG Development Group was established and that a plan was in place to ensure that all policies were updated, printed and circulated in the near future.

The provider had ensured that there was an up-to-date annual review of the quality and safety of care and support in place. The unannounced six monthly provider led audit took place in January. Areas for improvement were noted and documented in the centre's quality improvement plan. However, the inspector found that although the centre was effectively resourced on the day of inspection there were significant concerns in relation to the manager's ability to provide staffing resources in line with the statement of purpose and this is expanded on below.

The person in charge maintained a planned and actual staff roster. A review of these rosters found that the number and skill-mix of staff on the day of inspection was suited to the needs of the residents. Nursing support was was available. However, the inspector saw that there were numerous changes to the roster and significant gaps in staffing. For example, on six out of ten days recently, there was one staff nurse on duty when two staff nurses were required. Although, the provider had an on-call arrangement in place, the person in charge told the inspector that it was very difficult to secure relief staff. The provider also had a recruitment

campaign in place, however despite these efforts, it was evident that the service operated at a level below the core staffing requirements at times. The residents' high support needs were outlined above. For example, two residents had 1:1 support in place in accordance with their behavioural support plan. The support of trained, consistent staff who were familiar with their needs was crucial to the provision of a safe service. This support was provided by a small number of trained and experienced core staff on an ongoing basis. With regard to gaps in nursing support, the person in charge provided relief regularly. This included providing nursing cover while staff had rest breaks, nursing support for outings, and day time and evening support. Furthermore, the inspector found that this was a large premises and there were no cleaning staff employed. This meant that the staff on duty were required to provide care and support to the residents and to keep the premises clean and tidy. This situation was not in line the requirements for a consistent and safe service and was not sustainable.

A review of training records in the centre showed that staff had access to appropriate training, including refresher training as part of a continuous professional development programme. The person in charge told the inspector that a training needs analysis was completed and a new training matrix was in use. This was in line with the actions on the provider's compliance plan and was described by the person in charge as very effective. A sample of training records were reviewed and the inspector found that all modules were up to date apart from one. In this case, a plan was in place for the staff member to attend training at the end of the week. However, due to inconsistencies in staff provision in this centre it was difficult for the person in charge to ensure that staff could be released from the service in order to attending the training events that were organised. This will be expanded upon under the section on risk in the next section of this report.

The inspector reviewed the incident management system used in the centre and found that it was used appropriately to report concerns. Monitoring notifications were reported to the Chief Inspector in a timely manner and in accordance with the requirements of the regulation.

The next section of this report will describe the care and support that people receive and if it was of good quality and ensured that people were safe.

Regulation 15: Staffing

The registered provider was unable to ensure that a sustainable number and skill mix of staff which was appropriate to the number and assessed needs of residents was provided

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training as part of a continuous professional development training programme.

Judgment: Compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangement at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO 1.

At the time of inspection, the person in charge spoke with the inspector about eight of the actions that had commenced. Seven of these related to setting up of committees and meetings that had commenced. For example, at county level the person in charge meetings had commenced. However, the person in charge told the inspector that it was difficult to attend at times due to staff shortages. The policy, procedure, protocol and guidelines development group meetings had commenced and the person in charge was aware of the work being completed. At network level, the governance for quality safety service improvement meeting had held one meeting where the terms of reference were agreed and a plan was in place for the safeguarding review meetings was in place. At centre level, the meeting between the person in charge and the director of nursing had commenced and an additional local person in charge meeting was held for the particular geographical area where this designated centre was based. Staff governance meetings in the centre were occurring regularly and in line with the compliance plan.

The three actions remaining were are county level and did not require the direct input of the person in charge. Therefore, they were not aware of the status of those actions on the day of inspection. These included; Regulation, Monitoring and Governance meeting, the Disability Governance Meeting and the Human Rights Committee Meetings.

In general, although there was a good management structure in place in the designated centre, the inspector found gaps in the provider's ability to provide effective oversight of the staffing arrangements in place. This required improvement in order to ensure that sufficient, consistent, experienced and trained staff were available in order to provide a quality and safe service at all times.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was available for review and it contained the information required under Schedule 1 of the care and support regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that monitoring notifications were reported to the Chief Inspector in a timely manner and in accordance with the requirements of the regulation.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider has a range of policies, procedures and guidelines which were available and accessible for staff's use. A sample of policies were reviewed and some were found to be out of date. A plan was in place to ensure that all policies were updated, printed and circulated in the near future.

Judgment: Substantially compliant

Quality and safety

Residents living in the James Connolly Memorial Residential Unit were provided with good level of care and support and there were efforts made to improve their home. However, improvements were required with the nature of the premises provided which was institutional and outdated. Furthermore, practices in relation to infection prevention and control required review to ensure that a good quality and safe service was provided at all times.

The inspector reviewed a sample of residents' care plans and person-centred plans. The review found that annual reviews were taking place, that they were person-centred and where possible residents' families were involved in this process. Each resident had a named keyworker and there was evidence of goals agreed and pursued. For example, one resident enjoyed trips to the chapel, going on bus

outings and visiting their brother. Residents had access to the services of a general practitioner and to allied health professionals if required. They attended speech and language therapy, occupational therapy, physiotherapy, dietitics, audiology, ophthalmology and mental health services if required. Furthermore, the person in charge had an audit tool in place which ensured that eligibility for national screening programmes was reviewed annually and that appointments with the breast and bowel check service were followed up on if required. Each resident had a health passport in place which would assist and support if transferred to hospital.

As mentioned previously, the food served in James Connolly Memorial Residential Service was prepared in a professional kitchen. The inspector was present during dinner time and saw the food served was wholesome and nutritious and that two meal choices were provided. Residents had access to assistance with eating and drinking if required and as mentioned, a smaller kitchen was available for serving of drinks and snacks when the main kitchen was closed.

Residents that required support with behaviours of concern had positive behaviour support plans in place. These were reviewed and updated regularly and there was evidence of the involvement of allied health professionals in this process. For example, additional support from a speech and language therapist was in place. The provider had committed to this action as part of its recent compliance plan. The person in charge told the inspector that this support was very helpful and working well. The provider had a further six actions as part of its compliance plan and the inspector found that five of these were fully implemented and one was implemented partially. This related to the fact that the site specific induction pack was yet to be reviewed by the person in charge and the director of nursing/area co-ordinator. Restrictive practices were in use in this centre. There was a site specific protocol in place which was up to date. Furthermore, a restrictive practice log was in use and this was reviewed quarterly. All staff from the sample checked had training in positive behaviour support.

Safeguarding practices used in this centre were reviewed and the inspector found that residents were adequately safeguarded against potential abuse. The provider had a safeguarding policy in place and this was up-to-date and reviewed regularly. Where a concern arose, this was followed up on promptly by the person in charge and in line with safeguarding procedures. Safeguarding plans were developed as required. Safeguarding was a standing agenda item on the staff governance meetings which were held in the centre. All staff had training in safeguarding and protection of vulnerable adults and access to designated officers was provided. As part of the provider's compliance plan, a safeguarding tracker was to be introduced for each network area by the end of March 2022. At the time of this inspection, the safeguarding tracking log was in use and the additional weekly cross referencing of incidents had commenced. Training on preliminary screening of safeguarding concerns was provided and reported to be very helpful. Of the 13 actions proposed by the provider, there was evidence of 11 actions completed or in progress. However, the training on Speakeasy Plus was not achieved by the end of May 2022 which was the date given by the provider on the overview report. Furthermore, at the time of inspection the person in charge was not aware of the action in relation

to the peer support structure for designated officers.

As referred to earlier in this report, all residents were at the designated centre on the day of inspection and had not returned to their day services. This was discussed with the person in charge who told the inspector that there had been changes in the provision of day services and that some residents would benefit from the opportunity to return to activities outside the designated centre. The inspector found that although some activities were taking place on the day of inspection, most residents were not engaged in activities in accordance with their interests, capacities and developmental needs. Furthermore, centre-based activities were regularly changed and amended due to shortage of nursing staff to accompany residents on outings and to support them with their nursing needs. This required review.

This designated centre was located in an institutional setting. A de-congregation plan was in progress but remained at the early stages. The provider had addressed the maintenance concerns identified on the last inspection and these were nearing completion. However, the inspector found that the design of the premises was unsuitable for the needs of the residents. For example, residents were sharing dormitory sleeping accommodation with some distance to the closest toilet facilities. This meant that residents were at risk of disturbed sleep, lack of privacy and dignity and no private space for storage of their personal possessions.

There were systems and procedures in place for risk assessment and risk management. Risks impacting on residents were rated and escalated by the person in charge. These included a risk assessment on nursing staff shortages, a risk assessment on the lack of health care assistants and a risk assessment on the lack of provision of day service for seven residents. These were subject to regular review. Arrangements were in place for regular audits to be completed for example, annual health and safety audit, quarterly medications audit, monthly incident auditing and daily checks on cleaning and maintenance of the designated centre.

The provider ensured that there were systems in place for the prevention and control of infection. This included staff training, posters on display around the house about prevent infection transmission, use of personal protective equipment (PPE) and availability of hand sanitisers. In addition, there were systems in place for the prevention and management of the risks associated with COVID-19; including up-to-date outbreak management plans, risk assessments and ongoing discussion with staff about the risks of COVID-19. However, improvements were required with regard to the correct use of PPE in line with public health advice. This included the correct wearing masks to ensure that they cover both the nose and mouth and the appropriate use of gloves. For example, when in contact with blood or body fluids or when transmission based precautions are in use in the centre. These precautions were not in use on the day of inspection and the inspector found that staff were wearing gloves when it was not necessary.

Regulation 13: General welfare and development

Residents at this designated centre had not returned to their day services. The inspector found that although some activities were taking place on the day of inspection, most residents were not engaged in activities in accordance with their interests, capacities and developmental needs. Furthermore, centre-based activities were regularly changed and amended due to shortage of nursing staff to accompany residents on outings and to support them with their nursing needs.This required review.

Judgment: Not compliant

Regulation 17: Premises

A de-congregation plan was in progress for this designated centre but it remained at the early stages. The provider had addressed recent maintenance concerns and these were nearing completion. However, the inspector found that the design of the premises was unsuitable for the needs of the residents. For example;

- residents were sharing dormitory sleeping accommodation with some distance to the closest toilet facilities.
- residents were at risk of disturbed sleep, lack of privacy and dignity and no private space for storage of their personal possessions.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The food served in James Connolly Memorial Residential Service was prepared in a professional kitchen. The inspector was present during dinner time and saw the food served was wholesome and nutritious and that two meal choices were provided. Residents had access to assistance with eating and drinking if required and a smaller kitchen was available for serving of drinks and snacks when the main kitchen was closed.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems and procedures in place for risk assessment and risk management. Risks impacting on residents were rated and escalated by the person in charge. These included a risk assessment on nursing staff shortages, a risk assessment on the lack of health care assistants and a risk assessment on the lack of provision of day service for seven residents. These were subject to regular review. Arrangements were in place for regular audits to be completed for example, annual health and safety audit, quarterly medications audit, monthly incident auditing and daily checks on cleaning and maintenance of the designated centre.

Judgment: Compliant

Regulation 27: Protection against infection

The provider ensured that there were systems in place for the prevention and control of infection. This included systems in place for the prevention and management of the risks associated with COVID-19; including up-to-date outbreak management plans, risk assessments and ongoing discussion with staff about the risks of COVID-19. However, improvement were required with regard to the correct use of PPE in line with public health advice. This included;

- the correct wearing masks to ensure that they cover both the nose and mouth
- the appropriate use of gloves. The inspector found that staff were wearing gloves when it was not necessary.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that residents had an annual assessment of their health, personal and social care needs. These were person centred and included consultation with family members where appropriate.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a medical practitioner and to allied health professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements in relation to positive behavioural support. One action related to multi-disciplinary supports, three actions related to staff training and in ensuring staff had adequate knowledge about behaviour support plans and three actions related to the induction of new staff.

On the day of inspection, the person in charge told the inspector that the additional support of a speech and language therapist was in place. With regard to training, there was evidence that a new training matrix was in use and this was reported to be very helpful. Furthermore, there was evidence of that training needs were reviewed and discussed at person in charge meetings at centre level and at county level. The person in charge told the inspector told the inspector about the induction process that was taking place there and the specific actions from the overview report remained ongoing.

Residents that required support with behaviours of concern has positive behaviour support plans in place. These were reviewed and updated regularly. Restrictive practices were in use in this centre. There was a site specific protocol in place which was up to date. Furthermore, a restrictive practice log was in use and this was reviewed quarterly. All staff from the sample checked had training in positive behaviour support.

Judgment: Compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements in relation to safeguarding and protection.

A safeguarding tracker log was to be introduced for each network area by the end of March 2022. At the time of this inspection, the safeguarding tracking log was in use and the additional weekly cross referencing of incidents had commenced. Training on preliminary screening of safeguarding concerns was provided and reported to be very helpful. Of the 13 actions proposed by the provider, there was evidence of 11 actions completed or in progress. The training on Speakeasy Plus was not achieved by the end of May 2022 which was the date given by the provider on the overview report. Furthermore, at the time of inspection the person in charge was not aware

of the action in relation to the peer support structure for designated officers.

The inspector found that there were arrangements in the centre for safeguarding. The provider had a safeguarding policy in place and this was up-to-date and reviewed regularly. Where a concern arose, this was followed up on promptly by the person in charge and in line with safeguarding procedures. Safeguarding plans were developed as required. Safeguarding was a standing agenda item on the staff governance meetings which were held in the centre. All staff had training in safeguarding and protection of vulnerable adults and access to designated officers was provided.

Judgment: Substantially 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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for James Connolly Memorial Residential Unit OSV-0002502

Inspection ID: MON-0036896

Date of inspection: 29/06/2022

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to come into compliance with this regulation the following actions are being taken: 1. A recruitment campaign for staff nurses within disability services inclusive of graduate nurses who will qualify October/November 2022 has been completed. Completion date 27/06/2022. 2. The service is awaiting appointment of vacant positions by the HSE HR department. Completion date 30th November 2022 3. The Person In Charge will undertake a review of the staffing levels and skill mix taking into consideration the reduced number of residents in the centre from 12 residents to 10 residents. Completion date 30th September 2022	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to come into compliance with this regulation the following actions are being taken: 1. Donegal Regulation Monitoring and Governance meetings continues weekly with Donegal Disability Management Directors of Nursing and Area Coordinators and is chaired by the General Manager and supported by the Regional Director of Nursing CHO1 Disability Services . The most recent meeting took place on the 5th August 2022.	

2. Donegal Disability Governance meeting takes place monthly with representation from across Disability, Physical and Sensory and Children's Disability Network Teams commenced March 2022. The next meeting is scheduled for the 19th August 2022.

3. Human rights Committee meetings are held monthly. Members include Donegal Disability Managers, Directors of Nursing/Area Coordinators, Clinical Psychology lead, Social Work Team lead and a safeguarding representative. These commenced 27th of April 2022. Dates for the year and minutes from these meetings are circulated to all Persons in Charge. The next meeting is scheduled for the 7th September 2022.

4. Feedback from the above meetings is provided fortnightly at the Persons In Charge meetings. Next Person in Charge meeting is scheduled for 25th September 2022.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
In order to come into compliance with this regulation the following actions are being taken:

1. Practice Development Coordinator in conjunction with IDS policy group have reviewed and updated all policies and procedures. Completion date 21st July 2022
2. The updated policies have been circulated to the Person in Charge. Completion date 31st July 2022.
3. Person in Charge has developed a plan to ensure all staff read and sign updated policies. Completion date 15th September 2022.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
In order to come into compliance with this regulation the following actions are being taken:

1. Recruitment campaign for a Day Service Manager and staff nurses has commenced. Completion date 30th November 2022
2. The Assistant Director of Nursing will undertake a review of the appropriate skill mix required to expedite the resumption of this day service. Completion date 30th September 2022.
3. There is an activity coordinator in place in this centre whose role is to coordinate social and recreational activities in conjunction with the residents.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to come into compliance with this regulation the following actions are being taken:

1. The PIC will undertake a review of dormitory sleeping arrangements to ensure privacy and dignity for the 10 residents residing in the centre. Completion date 31st August 2022.

2. This residential centre has been prioritized for Decongregation. Completion date 31st December 2023.

3. Regular MDT meetings for the centre takes place to support the transition of residents to their new homes.

4. Monthly IDS Decongregation meetings which includes the JCM decongregation plan. Representatives from the Estates department, Property Management department, HR Department and Disability Services. Next meeting planned for the 31st August.
5. Residents from the centre will be moving to purpose built houses.
6. The HSE Property Management department, Estates department and Disability service is currently in the process of procuring 3 suitable sites in the Inishowen area, County Donegal.
7. Construction of 3 purpose built houses: Completion date 31st December 2023.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
In order to come into compliance with this regulation the following actions are being

taken

1. The correct use of PPE and gloves was discussed at a team meeting. Completion date 27th of July 2022.
2. Staff are to re-do PPE training on hseland by next staff meeting. Completion date 23rd of August 2022.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In order to come into compliance with this regulation the following actions are being taken:

1. Safeguarding and Protection team have undertaken training for Designated officers, Persons in Charge and managers. Completion Date 19th May 2022
2. A list of all Designated officers has been collated and forwarded to all centers for peer support. Completion date 15th August 2022.
3. Designated officer nominees have been sent to safeguarding office for further training. Completion date 31st October 2022.
4. Speakeasy plus training for professionals was provided to those staff who were nominated to complete this training. Completion date 25th May 2022. This training will be offered again across the CHO1 before December 2022.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/11/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/11/2022
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	Not Compliant	Orange	30/11/2022

	purpose and the size and layout of the designated centre.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/12/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	25/09/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	25/09/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated	Substantially Compliant	Yellow	23/08/2022

	infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	15/09/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	25/05/2022