

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0005249
<b>Centre county:</b>	Donegal
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Kathleen Doherty
<b>Lead inspector:</b>	Thelma O'Neill
<b>Support inspector(s):</b>	Jillian Connolly; Jude O'Neill; Rachel McCarthy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	40
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

**Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 4 day(s).

**The inspection took place over the following dates and times**

From:	To:
08 March 2016 09:00	08 March 2016 18:00
09 March 2016 07:00	09 March 2016 20:30
10 March 2016 14:30	10 March 2016 22:30
11 March 2016 09:00	11 March 2016 15:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

This was the second inspection of this centre by the Health Information and Quality Authority (the Authority). This inspection was to assess this residential service for registration under the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The findings of this inspection identified significant risks to the safety and welfare of residents in this centre. As a result the registration inspection was postponed and a specific safeguarding and risk management inspection was carried out instead.

Inspectors identified several allegations of abuse that had not been appropriately reported to management or when reported, had not been properly investigated in accordance with national safeguarding policies or procedures. This resulted in vulnerable residents not being adequately safeguarded and in one instance not believed by staff when they reported an allegation of abuse.

Inspectors also found serious failings in the governance and management of this centre which impacted on the quality and safety of care provided to residents. There was limited evidence of on-going audit to inform and support decisions in regards to

risk management. Six-monthly unannounced visits and an annual review by the provider had not been carried out.

There were no arrangements in place to support, develop and performance manage staff and gaps were identified in the mandatory training provided to staff in regards to fire safety, the management of behaviour that challenges and the protection of vulnerable adults.

Non compliances were also identified in relation to the delivery of healthcare, risk management, the management of residents' health and social care needs, residents' rights, dignity and consultation; and staffing.

During the inspection, the findings were shared with the person in charge, the provider nominee and the Intellectual Disability Services Manager. The provider was asked to take immediate action in response to the serious safeguarding and risk issues identified on inspection. Following the inspection, the provider responded to the Authority in writing, giving assurances that they had commissioned a team of external managers in quality improvement and risk management to review the service and to report back to the Authority on their findings and the actions taken to ensure that residents are safe.

The Action Plan at the end of the report identifies areas where significant improvements are required to comply with the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

**Section 41(1)(c) of the Health Act 2007. Compliance 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.**

**Outcome 01: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**

Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

At the outset of the inspection, inspectors were informed by the person in charge that there one minor complaint by a family member. However, inspectors identified numerous instances whereby residents and relatives had expressed dissatisfaction with the service but these concerns were not recognised or documented as complaints. As a result, complaints were not appropriately investigated or managed in accordance with regulations or the centre's policy and procedures on complaints. Furthermore; from reviewing one recorded complaint, inspectors formed the view that the matter should have been investigated under the centre's safeguarding procedures due to unexplained bruising/marks on the resident's chest and neck area.

Inspectors reviewed the systems in place for the management of residents' personal property and finances and identified four specific areas of concern. These were as follows.

- One resident had paid for a highly specialised chair. This was not in keeping with the HSE policy on managing patient private property (P.P.P.). These guidelines state that any items or assistive devices, assessed as required by the appropriate allied health professional and considered necessary for the care of the resident, should be purchased by the provider. This resident had fulfilled all of the criteria, but was still required to purchase the chair.
- Inspectors also became aware that residents' money had gone missing on three separate occasions. The latest was recorded in November 2015. Two investigations were still ongoing and the third concluded with the resident being reimbursed the missing

money. A review of the documentation confirmed that residents and where appropriate, relatives/representatives had not been informed of the missing money and the matter had not been reported to an Garda Síochána.

- Inspector found that residents had been issued with two contracts. One contract was issued from the service provider and outlined the level of services and staff support that would be provided. The second contract was a tenancy agreement with a Housing Association. From the sample of contracts reviewed, residents or their representatives had not signed these agreements and there was no evidence that the charges stated in the contracts had been agreed by residents or their representatives.

- Inspectors were not assured that residents had the opportunity to exercise choice and control over their lives in the centre. A number of residents did not have person centred plans in place with individualised goals for the current year. There was no evidence of consultation with residents such as weekly meetings that would provide residents and/or their representatives with the opportunity to make decisions about their lives within the centre.

Residents' daily activities were in the main collective, short, led by routine, and basic care needs. Inspectors observed residents attending social activities in the main hall for short periods of time and in large numbers. Activities were primarily campus based and located in one main hall. The provision of activities appeared in large part to have been designed around staff meal breaks instead of the individual needs of each resident. Inspectors were informed by the person in charge that residents' meal times were early (12.30pm) based on the need to ensure that all staff had an adequate lunch break. This was impacting on residents' choice, rights and opportunity to make decisions about their lives.

**Judgment:**  
Non Compliant - Major

### **Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**  
Effective Services

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Policies and procedures were in place for the prevention, detection and response to fire and there was evidence that fire drills had been conducted in the designated centre. However, inspectors found that improvements in procedures and staff knowledge were required to ensure that effective evacuation procedures were in place. Issues identified

during the inspection included the following:

- The fire alarm system covered the entire centre; therefore, if there was a fire in one house, the alarm would ring in every house. Although there were fire panels in each house and fire evacuation procedures displayed on the wall in each house adjacent to the panel, this did not provide guidance on the procedure to be followed in the event of a fire in another house
- a number of staff members gave conflicting accounts of the actions they would take in the event of a fire in another house
- a number of self closing fire doors were seen to have been wedged open with wooden door wedges or pieces of furniture including chairs
- intumescent strips were found to be compromised or were missing on some doors; and gaps were evident in double doors
- fire training records showed that 10 staff had still not received an update in training in the prevention and management of fire despite this being a requirement arising from the previous inspection of the centre.

There was no clear system in place to identify the staff training history for individuals working in this centre. Inspectors were provided with a list of names of 150 staff who worked within three services managed by the same person in charge. From the list provided, it was not clear which staff worked in this designated centre, or which staff had up to date mandatory fire training. The evidence reviewed by inspectors was indicative of poor oversight and organisation in relation to staff training within the centre.

Resident's daily nursing notes and accident/incident forms prior to January 2016 had been archived and were not available to inspectors. Documentation including incident/accident forms, resident care records, records of investigations and complaints and staff files were made available following a discussion with the Intellectual Disabilities Services Manager. Access to resident's documentation prior to January 2016 was required to review risk and risk management procedures in the centre. From the documentation reviewed, inspectors concluded that there were inadequate systems in place to ensure that individual or organisational risks were appropriately assessed, managed or kept under continuous review.

Inspectors found that appropriate safeguards and preventative control measures had not been put in place to mitigate risk of injuries to residents associated with falls in this centre. Inspectors were given a list of 38 falls by residents over a six month period (May to December 2015). One resident had fallen eleven times during this period. Two other residents were found to have had serious injuries requiring hospitalisation as a result of falls. From the records reviewed, inspectors found that appropriate safeguards such as additional staff support, appropriate falls risk assessments and post-fall reviews by the multidisciplinary team had not taken place to safeguard these residents. Inspectors also found that the centre's organisational risk management policy had not been adhered to in practice in relation to accidental injury to residents.

**Judgment:**  
Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**

Safe Services

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Inspectors found significant evidence of allegations or indicators of abuse which had not been managed in a way to ensure the safety of residents and which had not been investigated in line with national safeguarding procedures.

Two requirements made following the last inspection on 3 July 2014 in relation to staff training and local procedures to guide staff in the event of an allegation of abuse being reported had not been addressed. The provider had stated in their action plan response that all staff would be made aware of the procedure through discussion at staff meetings and shift handovers. This had not occurred and 14 staff had yet to attend update training on the protection of vulnerable adults.

At the opening meeting with the person in charge, inspectors were categorically told that there had been no incidents, suspicions, allegations or investigations of abuse in this centre since the commencement of regulation in November 2013. However, from speaking to residents and staff and reading daily care records, inspectors quickly identified that a number of allegations of abuse had been reported to persons participating the management of the centre and that formal investigations had taken place. This was also confirmed with the intellectual disability services manager. The person in charge subsequently provided inspectors with documentation of allegations of abuse that had been reported and one investigation that had taken place in 2015.

From review of the documentation provided by the person in charge and consideration of the information provided by residents, staff and from care records, inspectors concluded there was a significant risk to the safety of residents as a consequence of seriously inadequate safeguarding arrangements in the centre. Examples of this included:

- The procedures used by the person in charge and others participating in the management of the centre to investigate abuse were inconsistent and did not provide assurance to those making allegations that their concerns would be heard and adequately responded to.



- An inadequate approach to responding to allegations of abuse. Staff members were unaware/unclear as to the appropriate procedures to follow when reporting allegations or indicators of potential abuse. For example, inspectors identified one instance where a resident alleged that they had been struck by a member of staff. When asked by other staff to "act out " the alleged assault, staff concluded from the resident's response that the alleged assault was unfounded and did not report the allegation of abuse. In another example, a resident was inappropriately questioned by staff following an allegation of abuse and the person in charge failed to investigate the allegation in accordance with the centre's safeguarding policy and procedures.
- Inadequate consideration of past history of resident on resident abuse when planning with residents where they choose to live within the centre.
- Failure to carry out an appropriate risk assessment or put in place adequate control measures to protect residents from peer abuse. One example of this related to a resident with a significant past history of peer abuse yet there was an absence of this history in on-going assessments or care records despite staff confirming to inspectors that the risk still existed. Another example was evidenced in an incident which occurred in January 2016 when two female residents had been physically assaulted by a male resident while being transported in the car. Following the assault, no adequate action had been taken to safeguard the female residents and a further similar incident occurred during a car journey the following week.
- A number of staff informed inspectors that when they raised safeguarding concerns with the person in charge, they were either not listened to or felt they were seen as "trouble makers".

The management of aggressive behaviour was not managed in line with national guidelines and this posed a risk to residents and staff. While behaviour management plans were in place, these had been developed by nurses without guidance or input from a psychologist, behavioural support specialist or other members of the multi-disciplinary team. There was an absence of proactive or reactive strategy in residents' behaviour management plans, or when present, these were not consistently or appropriately implemented into practice. For example, in one house, inspectors were told by staff that two male staff members were required to be present as a risk management control measure. However, on review of staff rosters, inspectors found that female staff were regularly left on their own to supervise residents. In one instance; inspectors were informed that a male resident had to be physically and chemically restrained following an aggressive outburst when female staff were left alone in the house.

Inspectors identified a number of examples of residents being physically restrained by staff including one incident where four staff members restrained and transferred a female resident to another location during a behavioural outburst. From review of the records relating to this incident, inspectors identified an absence of an appropriate behavioural management assessment or subsequent review to determine the appropriateness or otherwise of the intervention. The centre's operational policy advises that use of physical restraint should only be used following all alternative options having been utilised and where the resident or others are at significant risk of harm. This policy

had not been followed in the incidents reviewed by inspectors. Furthermore; there were significant staff training deficits in the management of behaviour that challenges and the staff members involved in physical restraint lacked training in the appropriate techniques which put residents at significant risk of unnecessary injury.

Inspectors identified that chemical restraint was frequently used in this centre. Inspectors were told that it was used as a form of therapeutic intervention. In one case chemical restraint had been administered to one resident, 44 times in a two month period. However, there were no specific protocols in place to indicate when it should be used audits completed to identify the frequency of chemical restraint being used. These tools would ensure that staff administering the medication were aware of the clinical rationale for such usage. The records reviewed by inspectors indicated that chemical restraint was used in every house on a very regular basis.

**Judgment:**  
Non Compliant - Major

#### **Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**  
Safe Services

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
A record of all incidents occurring in the designated centre had not been appropriately maintained by the person in charge. Furthermore, there were only three notifications submitted to the Authority since the commencement of Regulation in 2013. Notifications required within three days of the accident/ incident or quarterly notifications were not notified to the Chief inspector as per Regulation 31, Schedule 4.

**Judgment:**  
Non Compliant - Major

#### **Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**  
Health and Development

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The evidence found by inspectors indicated that the healthcare needs of residents were not attended to in a timely manner and that this had a significant impact on the health and wellbeing of residents. The seriousness of this issue was compounded by the fact that this is a nurse-led service.

While residents had access to their general practitioner (GP), an annual medical review had not been completed for each resident. In addition; the nursing assessments did not adequately identify the current healthcare needs of each resident which resulted in an absence of appropriate plans of care or the supports residents required to ensure their healthcare needs were met. As a result inspectors found serious deficits in the care provided to some residents in the centre, which resulted in negative outcomes for these residents. Examples of these included the following:

- One resident was admitted to hospital following a fall. While in hospital, the resident was diagnosed with a fracture to her spine. Although it was not possible to determine when the fracture had occurred, the nursing notes record the resident complaining of back pain following another fall. At the time, the resident's concerns had not been properly responded to by staff or the resident sent for further investigation.
- Inspectors found evidence of two residents suffering from pressure ulcers. However, there was no documentary evidence that the residents were seen by a tissue viability nurse or that their wounds or dressings were being attended to by staff with training in wound care. For example; the inspector met one of the residents/staff having come back from attending the fracture clinic in the hospital and was told that the pressure wounds were not reviewed at the hospital and that the wounds urgently required re-dressing; but the staff confirmed to the inspector that they had not received specialist training in tissue viability/ wound care.
- In October 2015, a resident had an Occupational Therapy (OT) assessment. The file note reviewed by inspectors stated that staff informed the OT that the resident did not have a documented history of falls. However, inspectors identified that this resident had a number of documented falls and that the OT was not provided with accurate information to make an informed decision of this residents need for falls prevention equipment. This resident subsequently had a serious fall which resulted in a significant head injury.
- Staff failed to assess the seriousness of a head injury to a resident and instead of contacting emergency services waited 70 minutes on the GP to arrive who subsequently referred the resident to hospital where they received two sutures and 20 staples for a laceration to their head.
- Inspectors found that despite the serious fall referenced above, adequate measures were not put in place to prevent this resident from further falls and they subsequently

had three more falls, one occurring only eight days following the serious fall that required hospitalisation.

- A number of epilepsy management plans had not been adequately reviewed or updated following medical reviews. In one instance, a resident's epilepsy management plan had not been updated since January 2015. This resident had been seen by a neurologist in January 2016 and the recommendations from the consultant had not been included in their epilepsy care plan following the review.
- Resident's care plans did not provide accurate and up to-date information for staff when delivering care. For example; in the case of one resident who experienced seizures while in the bath, their risk management plan did not refer to this risk and subsequently adequate control measures had not been put in place.

The protocol for the administration of emergency medication was ambiguous, not clear to staff and therefore created a risk for residents. The protocol stated that two doses of emergency medication could be administered within eight minutes of a seizure and that further emergency medication could be administered within 10 minutes. However, a nurse who spoke to inspectors about the protocol was unclear regarding the timelines and doses to be administered; either three doses could be administered within 10 minutes of the seizure or having waited a further 10 minutes after initially administering two doses of emergency medication, a third dose could be administered.

Inspectors also reviewed the catering arrangements within the centre. Food was transported to the centre twice a day from a central kitchen located in the main building. There was no choice of hot meals available to residents; although an alternative cold option was available should a resident not like the only hot meal option. The delivery of food from a centralised kitchen limited residents' opportunity to become involved in sourcing and preparing their meals.

**Judgment:**  
Non Compliant - Major

#### **Outcome 14: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**  
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**

Inspectors found that the poor governance and oversight arrangements in the centre had a direct, negative impact on the safety and quality of life of residents.

From the documentation reviewed and discussion with residents and staff, inspectors did not have confidence in the fitness of the person in charge to manage the centre. Inspectors concluded from the evidence found that the national policy on safeguarding vulnerable adults had not been appropriately implemented and that responses by management to allegations did not prioritise the safety of residents. Examples of why inspectors arrived at this conclusion are documented throughout this report. In particular, inspectors were deeply concerned by the categorical denial of the person in charge and another person participating in the management of the centre that there had been any allegations, incidents or suspicions of abuse, something which was clearly not the case.

While there was an organisational structure in place, that identified the governance and management arrangements in place within this centre, the provider had failed to ensure that appropriate and safe care had been provided to residents and that adverse incidents were appropriately managed. No unannounced visits or annual review had been undertaken by the provider since the commencement of regulations to assess the quality and safety of care being delivered.

There was no evidence that staff had regular team meetings with their managers to discuss on-going issues relating to the management of the centre and/or individual houses within the centre.

The person in charge did not ensure that there was adequate monitoring of the healthcare needs of residents, with associated healthcare plans to reduce risk to the health and welfare of residents. The lack of monitoring of residents general health issues such as falls, epilepsy management and wound care had resulted in significant health implications for a number of residents.

There was a lack of audits of the care provided to residents to inform and support care decisions and risk management. Relevant information was not available for staff providing care, and the documentation held in relation to risk management was poor in relation to abuse, healthcare issues, complaints, staffing, and notifications.

There were no adequate arrangements in place to support, develop and performance manage all members of the workforce, which was required to ensure the quality and safety of the services being delivered.

Known and or identified risks had not been adequately managed to ensure that adequate systems and sufficient and consistent staff resources were in place to adequately meet residents' needs.

At the time of inspection, the centre had exceeded the number of residents that it could accommodate. The provider had previously notified HIQA, in compliance with Section 69 of the Health Act 2007 as amended, that the centre accommodated 39 residents. On the

day of inspection there were 40 residents living in the centre.

**Judgment:**  
Non Compliant - Major

**Outcome 17: Workforce**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**  
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The registered provider did not ensure that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre.

Although there appeared to be adequate numbers of staff employed in this centre, there was evidence of a very high sickness absence rate and inadequate management of the staffing resources available in this centre. A review of staff rosters showed frequent gaps in staffing in some houses. On some days there were only two staff on duty and later in the week, five staff had been rostered in the same house without any obvious reason for the increase. This was found by inspectors to have a negative impact on resident's lives in that the inconsistent staff numbers resulted in residents' social activities being cancelled or reduced. In some instances, residents' appointments had to be cancelled due to staff shortages.

The person in charge failed to ensure that the actual staff rota was reflective of the staff that worked in the centre. Frequently staff were rostered to work in one house, but were moved for short periods or full shifts to another house and this was not reflected on the staff roster. Inspectors found that it was not possible to accurately review the staff support provided to residents on a daily basis from the staff rosters maintained in the centre.

A review of the training records held for staff indicated that 83 staff had not received initial or update training in the management of behaviours that challenge, 10 staff had not received fire training and 14 staff had not received update training in protecting vulnerable adults. The systems in place to manage staff training were assessed by inspectors as inadequate. The records of staff training presented to inspectors included

all staff employed in three designated centres and it was difficult to determine training that had been provided or was still outstanding.

The person in charge also failed to ensure that the documentation required by the regulations to be in place in staff files had been included. Inspectors noted that contracts of employment, Garda Vetting and references were absent in the examples reviewed.

**Judgment:**  
Non Compliant - Major

### Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

#### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

#### ***Report Compiled by:***

Thelma O'Neill  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0005249
<b>Date of Inspection:</b>	08 March 2016
<b>Date of response:</b>	13 May 2016

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no evidence that contracts of care or tenancy agreements had been agreed by residents or their representatives.

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.



**1. Action Required:**

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

**Please state the actions you have taken or are planning to take:**

- All contracts of care & Tenancy agreements will be agreed with the service user/their representative and signed by the service user/their representative, Director of Services & Voluntary Housing Association representative
- All financial charges will be documented in Contracts of Care

**Proposed Timescale:** 30/06/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents were not provided with opportunities to exercise choice and control over their lives on a daily basis.

The activities which residents' participated in were in groups, for short periods of time, led by routine and had no individualised goals.

**2. Action Required:**

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

**Please state the actions you have taken or are planning to take:**

- All residents PCPs have been reviewed and updated by the named nurse and key worker in consultation with the resident and families/representatives, an audit of same to be completed by CNM's/PIC's by 31st July 2016.
- To provide residents opportunity to make decisions about their lives within the centre weekly residents meetings commenced on the 30th of March.
- The agenda is agreed with residents and minutes are documented.
- CNM's/PIC's to attend residents meetings on occasion to ensure a record is maintained of actions required including the name of the person responsible for ensuring actions are completed.
- Individual residents' daily activities are now planned in accordance with the residents' individual PCP goals.
- Activities outside of the centre for each resident who requests same will be responded to in a timely manner.
- A Community based Day Service Hub is in planning stage with envisaged attendees from the designated centres if they so chose.
- The Asdan programme will be made available which will promote the principles of New Directions.
- A retirement group is also in the planning stage with envisaged attendees from the designated centres.

- Service users will be accompanied by staff to both the Community based hub and the retirement group to avail of a wide variety of community based activities. Where service users choose to remain at home and access activities therein or choose to pursue other activities in the community arrangements will be made to accommodate these preferences.
- A consumer forum will commence which will involve residents, families, representatives, staff, Independent Advocate which will support a person centred community model. A letter has been sent to all families informing them of the intention to commence a Consumer Forum and inviting them to participate. The first forum is scheduled for 01/07/2016.

**Proposed Timescale: 31/07/2016**

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Residents had not been informed that their money had gone missing since November 2015.

The investigations into two incidents where residents money had gone missing were still outstanding and had not been reported to the Gardaí.

**3. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

**Please state the actions you have taken or are planning to take:**

- Residents or family / representatives will be informed if money is missing in future.
- An Investigation into the monies that had gone missing has been carried out by the Business manager for Intellectual Disability Services.
- Having identified that monies were missing, the Director of Services, prior to the HIQA Inspection had initiated this investigation. The investigation established that the monies that went missing on 30.10.15 and 9.12.15 were in different houses and there was no crossover of staff in relation to same. The investigation was carried out in adherence to the HSE fraud policy and concluded that the incidences did not warrant reporting to the Gardaí.
- The residents/families were informed that their money had gone missing on the 14/04/2016.
- The missing money was reimbursed to both residents on the 28/04/2016.
- New procedures have been implemented including regular checks of resident's monies as well as double signature arrangements for cash collections and expenditure from the PPP account.
- The HSE External Auditors were notified in relation to missing money.

**Proposed Timescale: 30/06/2016**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Individuals had expressed dissatisfaction with the service and these concerns were not documented as complaints. Therefore, they were not investigated and managed in line with the organisational and national policy on complaints.

**4. Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**

- A Complaints Officer was identified for each designated centre on the 15/06/2016.
- Complaints Officers and managers will attend training on complaints management on the 30/06/2016.
- Complaints Officers will link with Consumer Affairs Officer HSE when required.
- CNM's/PIC's commenced a complaints log in each house on the 22/03/2016.
- The complaints log will be reviewed each week by the CNM/PIC for each house and any actions required will commence immediately.
- CNM's /PIC's will ensure all complaints are investigated in accordance with the HSE complaints policy.
- Director of Services will monitor complaints in all designated centres on a quarterly basis commencing 15/06/2016 or more frequently if required.
- Complaints will be a standing agenda item at local governance meetings at designated centre level & management level.
- All Complaints will be reviewed under local governance group which will identify trends and patterns and agree on further action.
- Learning gained from complaints will be shared throughout the Donegal ID Service under quality Safety & Risk Governance Meetings.

**Proposed Timescale:** 30/06/2016

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were inadequate systems in place to ensure that individual or organisational risks were appropriately assessed, managed, or continuously reviewed.

**5. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**

- HSE Risk Manager CHO 1 will undertake a comprehensive review of the operational, clinical and environmental risks in the designated centre.
- The Risk Manager CHO 1 in conjunction with staff in the designated centre will identify control measures which minimise the risk to residents.
- The Risk Manager CHO 1 will oversee a process to ensure that identified control measures will be implemented, monitored and reviewed.
- All Risks identified in Individual Screening tool will be fully risk assessed and risk managed. These will be reviewed on a quarterly basis by Named Nurses and monitored by PICs when required.
- A Programme of Risk Management Training will commence throughout the Service. 3 CNM's/PIC's attended the training on the 08/06/2016. The remaining CNM/PIC will attend on the 16/06/2016. A training schedule for all staff will be devised in conjunction with the HSE Risk Manager.
- Risk Register in each Designated Centre will be monitored by PICS on an on-going basis.
- Risks are escalated as appropriate to DOS level and Service Manager Level & senior management
- An Emergency Contingency Plan has been devised to plan evacuations from designated centre in the event of Fire, Loss of Water and Loss of electricity, a copy will be disseminated to each area.
- A member of staff has been identified in each designated centre to undertake Health & Safety Rep Training on the 20th, 21st & 27th/06/2016.
- Quality Safety & Risk governance group to be established within the designated centre and meet on a bi-monthly basis to monitor risk management systems.

**Proposed Timescale:** 27/06/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was evidence that the centre's risk management policy was not adhered to in practice in relation to accidental injury to residents, visitors and staff.

**6. Action Required:**

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

**Please state the actions you have taken or are planning to take:**

- The Risk Management Policy for the centre will be reviewed in conjunction with the HSE Risk Manager on the 16/06/2016 and updated if necessary to include the measures and actions in place to control accidental injury to residents, visitors and staff.
- Following CNM's/PIC's attendance at the Risk Management training on the 08/06/2016 they will reinforce the relevant risk management policies with staff to ensure they adhere to the procedures to follow in the event of accidental injury to residents,

visitors or staff.

- CNM's/PIC's will outline the requirement for all staff to read and sign off on having read the relevant risk management policies.
- CNM's/PIC's will conduct an audit of staff sign off on Risk Management policies within the designated centre.

**Proposed Timescale:** 24/06/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Risk control measures were significantly inadequate based on the number and seriousness of incidents occurring in this centre. The adverse impacts on the residents' quality of life were not appropriately assessed based on the level of incidents and injuries identified in the centre.

**7. Action Required:**

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

**Please state the actions you have taken or are planning to take:**

- All Accidents / Incidents / near Misses reported under NIMS will be audited on a monthly basis by CNM's/PIC's to inform practice and decision making and promote welfare and safety of Residents.
- A Multidisciplinary Team review of all behaviour support plans commenced 26.05.2016 and concluded 02.06.2016.
- 03.06.2016 - The MDT agreed a protocol based on clinical criteria for the prescribing of restrictive practices where a resident's behaviour necessitates intervention as a last resort.
  - This protocol includes a system for ;
    - Assessment and prescribing of restrictive practice.
    - Record of each instance of restrictive practice.
    - Record of debriefing following each instance of restrictive practice.
    - Record of MDT review following each instance of restrictive practice to identify the learning that can be applied. (The review will involve the resident and /or their representative where appropriate).
  - An appropriately trained staff member and a psychology assistant have been enlisted to complete an assessment of each resident who requires support to manage their behaviour on week commencing 20.06.2016.
  - A team of staff who have completed the Multi Element Behaviour Support programme have been identified to support this process, this commenced on the 15/06/2016.
  - The most appropriate framework for positive behaviour support will be agreed and implemented.
  - A Clinical Psychologist has been identified to provide oversight.
  - A plan is in place to ensure all nursing and care staff receives training on Managing

Challenging Behaviour by the 24th of June 2016.

- To date (15.06.2016) 26 staff have completed the 5 modules required for this training, This includes the Director of Service and 3 CNM's/PIC's, The fourth CNM/PIC is scheduled to complete the training on return from annual leave 14.06.2016
- Managing behaviour will be a standing item on the agenda of monthly staff meetings.
- The behaviour support team will brief staff on behaviour support plans for residents in their care.
- Resident's Positive behaviour Support Plans will be reviewed in conjunction with resident, family/ representative where possible and MDT and individual risk assessments will be carried out. These plans will be reviewed on a quarterly basis or more frequent as required.
- A review has taken place of the compatibility of residents sharing accommodation and a plan is in place to suitably relocate residents within the service to ensure the service provided is safe and appropriate to residents' needs. 7 residents have been identified and the transition process commenced on the 7th of June 2016 and is ongoing.
- Residents will be encouraged and supported to make decisions and engage with their local community taking into consideration risk control measures proportional to any risks identified.

**Proposed Timescale: 31/10/2016**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A number of self closing doors had been held open with wooden door wedges or pieces of furniture which significantly diminished the fire doors effectiveness in the event of a fire.

Seals around the doors were also found to be compromised and there were gaps between some double doors.

**8. Action Required:**

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**

- All staff were advised on 11th March, 2016 by senior managers that no doors were to be wedged open at any time of day or night. This was followed-up with a memo to all staff on 18TH March 2016
- This action is being reinforced daily by senior managers, CNM's/PIC's and Director of Service to all staff on duty.
- Quotations have been received for self-closing doors and forwarded to Acting General Manager & Estates dept HSE on 19th April, 2016
- Seals around all doors have been replaced on 15th April, 2016

**Proposed Timescale: 31/07/2016**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The fire evacuation procedure was confusing as it did not provide guidance to staff on the procedure to follow if there was a fire in another house.

**9. Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**

- The Fire & Safety Officer, HSE Estates Department in conjunction with a third party contractor will carry out a comprehensive review of the fire management systems in the designated centre including environmental, clinical and operational factors.
- The Fire & Safety Officer, in conjunction with management of the designated centre will develop a Fire Management Policy which is reflective of the environmental, clinical and operational factors within the designated centre.
- PEEP updated for all service users.
- All staff to have fire safety training on an annual basis
- Fire drills in each house carried out in April 2016 and to continue on a rolling basis in future including day and night time drill.

CNM's/PIC's will complete a record following each drill detailing how, when & where the drill took place, who was involved and length of time taken to evacuate each person

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Ten staff members did not have fire training or up to date fire training. Staff members provided conflicting accounts of the actions to be followed in the event of a fire.

**10. Action Required:**

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

**Please state the actions you have taken or are planning to take:**

- All staff have completed regulatory Fire Safety Training with the exception of 3 staff that are on leave. These 3 staff will attend training prior to return to work.
- CNM's/PIC's will provide training for all staff on the Fire Management policy when reviewed.
- Fire Management will become a standing item on the agenda of monthly staff meetings within the designated centre.
- CNM's/PIC's will conduct and document random checks with staff using the

standardised template to consolidate knowledge of fire procedure.

- CNM's/PIC's will conduct an audit of staff sign off on Fire Management Policy
- All staff training to be tracked by the CNM/PIC for each house.

**Proposed Timescale:** 17/06/2016

## **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Staff did not have training to appropriately respond to behaviour that challenges and to support residents to manage their behaviour.

### **11. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

**Please state the actions you have taken or are planning to take:**

- A plan is in place to ensure all staff receives training on Managing Challenging Behaviour by the 24th of June 2016. The training consists of 5 modules as follows;

1. Introduction to Behaviours of Concern
2. Applying Positive Solutions
3. Recognising Triggers
4. Thinking about risk
5. The Sum of the Parts (recap)

- Training commenced on March 18th 2016 to date (15.06 .2016) 27 have completed the training; this includes the Director of Service and 4 CNM's/PIC's.

- Information on the content of the training has been disseminated to all designated centres for staff to read prior to training.

- The Service is in the process of reviewing alternatives to the current behaviour management system in place in this centre.

- The Acting Service Manager/Provider Nominee has contacted an alternative behaviour management training company to provide training where it is deemed necessary. When appropriate staff has received behaviour management training, the use of the current restrictive management techniques will cease in Donegal Intellectual Services.

- Managing behaviour will be a standing item on the agenda of monthly staff meetings.

**Proposed Timescale:** 24/06/2016



**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Therapeutic interventions recommended by psychologists, or behavioural support specialists were not available to residents that regularly displayed behaviours that challenge.

**12. Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**

- Following a HIQA directive all restrictive practice in the designated centre ceased at 1700 hours on the 31.05.2016 pending review by competent person.
- A Multidisciplinary Team review of all behaviour support plans commenced 26.05.2016 and concluded 02.06.2016.
- This review identified 10 residents as having a restrictive practice listed in their behaviour support plan.
- An audit was conducted to determine the frequency of use of restrictive practices in the previous 12 months for all 10 residents (31.05.2016).
- The MDT agreed a protocol based on clinical criteria for the prescribing of restrictive practices where a resident's behaviour necessitates intervention as a last resort 03.06.2016
- Using the agreed protocol the MDT approved and prescribed restrictive reactive strategies for 9 residents in the designated centre based on agreed clinical criteria.
- CNM's /PIC's have identified residents in the centre who may require a restrictive procedure for the purpose of a medical or health need. These cases will be reviewed by the MDT using the above protocol on the 20.06.2016.
- Resident's Positive behaviour Support Plans will be developed in conjunction with resident, family/ representative /Behaviour Support team & where possible and MDT. These plans will be reviewed on a quarterly basis or more frequent as required.
- Business cases have been completed and escalated to CHO 1 recruitment process for recruitment of appropriate members of the multi-disciplinary team to provide therapeutic interventions to service users that regularly display behaviours-that-challenge.
- The Acting Service Manager/Provider Nominee has issued a memorandum (13/06/2016) to all staff in the designated centre giving guidance on use of restrictive practices and the requirement for all staff to read the relevant policies and sign off on same.

**Proposed Timescale:** 24/06/2016

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Restrictive procedures such as; physical, chemical or environmental restraint were not used in accordance with national policy and evidence based practice.

All efforts were not made to identify and alleviate the cause of residents challenging behaviour and to put alternative measures in place prior to restrictive measures being put in place.

**13. Action Required:**

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**

- Behaviour Support Plans being developed with resident, family / representative and MDT will identify proactive and reactive strategies.
- Any restrictive Procedure involving Care and Responsibility will be agreed with resident, family / representative and MDT. See response to Regulation 07 (2) page 24/25
- Behaviour Support Plans will be reviewed on a quarterly basis or more frequent if required.
- A monthly audit and evaluation of restrictive practices to be completed by PICs and reviewed at Local Quality Safety & Risk Committee quarterly commencing 22/06/2016.
- An education/training programme will be provided in relation to managing behaviours of concern and will include de-escalation techniques. See response to Regulation 07 (2) page 24/25.

**Proposed Timescale:** 24/06/2016

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents had reported to staff that they had experienced abuse in this centre; however, allegations of abuse were not adequately investigated as per organisational policy and procedures.

**14. Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

**Please state the actions you have taken or are planning to take:**

- Staffs first priority on receipt of an allegation of abuse is to ensure that the Resident is protected and safety is maintained.
- All allegations of abuse will be dealt with under the National policy for Safeguarding of Vulnerable Persons at Risk of Abuse.
- Safeguarding Training for designated Officers will be delivered to all PICs/CNM's when

dates have been secured.

- All Allegations will be notified to HIQA, CHO1 Safeguarding Team & on the National Incident Management Forms.
- All Allegations will be thoroughly investigated using HSE National Policies of Safeguarding Vulnerable Persons at Risk of Abuse and Trust in Care.
- Monthly MDT meetings are scheduled to monitor safeguarding concerns – Commenced on the 14th of April 2016 and ongoing.
- Social Worker for adults with Intellectual Disability commenced meetings with service users on 20th April, 2016 providing them with support using easy read guides on safeguarding
- A meeting between the Designated Officers and the Donegal Safeguarding Team commenced on 15/06/2016 to monitor issues and share learning, to held bi monthly.
- All PIC's will track and trend safeguarding issues on a monthly basis and these will be reviewed at Local Quality Safety & Risk Committee quarterly.

**Proposed Timescale: 30/06/2016**

**Theme: Safe Services**

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The person in charge failed to initiate and put in place an investigation in relation to allegations or suspicion of abuse and take appropriate action where a resident alleged they or their peers were harmed or suffered abuse.

**15. Action Required:**

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**

- Staffs first priority on receipt of an allegation of abuse is to ensure that the Resident is supported protected and safety is maintained.
- Resident's family / Representative will be notified of all allegations of Abuse.
- All Allegations will be thoroughly investigated using HSE National Policies of Safeguarding Vulnerable Persons at Risk of Abuse and Trust in Care.
- The necessary NIMS, Safeguarding and HIQA NF06 forms will be completed & submitted within the required timeframes.
- Onward referrals to MDT where appropriate.
- Provide Easy Read documentation for residents on Safeguarding.

**Proposed Timescale: 30/04/2016**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The person in charge had not ensured that all staff had received the appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**16. Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**

- Training and Education on Safeguarding Policy and procedures commenced on 24th March 2016 and is ongoing until all staff has completed this training.
  - A programme of Safeguarding Awareness training has been rolled out by the CHO 1 Safeguarding Team to ensure that all staff (101 in total) in the designated area is aware of the Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures (December 2014).
    - o 8 staff attended on the 24th of March 2016
    - o 3 staff attended on the 1st of April 2016
    - o 19 Staff attended on the 15th of April 2016
    - o 24 staff attended on the 2nd of June 2016.
    - o 37 Staff attended training on the 09.06.16
    - o 10 staff attended training on the 13th of June 2016.
- As of 13/06/2016 all 101 staff have received Safeguarding Awareness training.
- The Acting Service Manager/Provider Nominee has issued a memorandum (09.06.2016) to all staff reinforcing the requirement for staff to read and sign off on the Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures (December 2014) and the Donegal Intellectual Disability Service Guideline for the Reporting of Concerns Regarding Vulnerable Persons at risk of Abuse (February 2016) to ensure they are familiar with the categories and indicators of abuse and the procedures to be followed in the event of an allegation or suspicion of abuse.
  - A Staff Questionnaire has been developed to be completed randomly with staff at all levels in order to consolidate staff knowledge of safeguarding processes.
  - Staff have been formally notified in writing of all contact details of Confidential Recipient, Designated Officers outside the centre and the Adult Social Work Team in Donegal. Details of the Good Faith Reporting Process, Protected Disclosure Policy were also provided to all staff members on 25th March 2016.
  - All staff have been invited to meet with the Donegal ID Service Manager to highlight the safeguarding concerns in the service.
  - Staff Questionnaires were issued to all staff week beginning 9th May to ascertain staff views on Services.

**Proposed Timescale:** 30/06/2016

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents that reported abuse were not supported during or after the process.

**17. Action Required:**

Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

**Please state the actions you have taken or are planning to take:**

- Social Worker for adults with Intellectual Disability commenced meetings with service users on 20th April, 2016 providing them with support using easy read guides on safeguarding.
- CNM's/PIC's to ensure all staff are made aware of the necessity to support all service users who wish to make an allegation of abuse.
- Safeguarding will be a standing item on the agenda of monthly staff meetings in the designated centre.
- CNM's/PIC's will conduct random checks with staff using the HIQA sample safeguarding interview questions to consolidate knowledge.
- All allegations of abuse to be reported on NIMS, to CHO 1 Safeguarding team and HIQA – a safeguarding plan to be developed with the resident, where possible and implemented as per national Policy Safeguarding Vulnerable persons at risk of abuse.
- PIC's will continue to collaborate with Relationship and Sexuality trainers in Donegal to ensure service users avail of appropriate training in relation to Relationship and Sexuality.
- Train the trainer programme will be delivered for Relationships and Sexuality training. Two trainers will be facilitated to attend.

**Proposed Timescale:** 30/06/2016

**Outcome 09: Notification of Incidents**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There were only three incidents and accidents notified to the Authority since the commencement of Regulation.

**18. Action Required:**

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

**Please state the actions you have taken or are planning to take:**

- The Person in Charge will notify HIQA of all 3 day Notifiable Events and Quarterly Notifications.
- The Director of Services will ensure all HIQA Notifications are submitted by PICs in a timely fashion.
- All notifications to HIQA will be reviewed, tracked and trended via HIQA Steering Committee.

**Proposed Timescale:** 05/05/2016

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Residents' that required reviews by their General Practitioners and allied health professionals such as social workers, psychologists, physiotherapists and Tissue Viability nurses were not provided access to same in a timely manner.

**19. Action Required:**

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

**Please state the actions you have taken or are planning to take:**

- Provider led Investigation reviewed 22 residents Case Documentation and found the majority of Residents referrals is prompt and followed up, however in some files there was evidence to demonstrate that delays may occur.
- All PIC's will ensure the named nurse in each house will arrange for all service users to be scheduled for an annual medical review with their GP.
- All service users personal plans to be reviewed quarterly, or sooner if required, including review of ongoing medical needs and access to medical professionals arranged if required
- Local Guideline regarding referrals to Allied Professionals and Care Pathways to be implemented.

**Proposed Timescale:** 15/06/2016

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The person in charge failed to ensure that residents received adequate medical and psychological support at times of illness or following accidents and injuries in this centre.

**20. Action Required:**

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

**Please state the actions you have taken or are planning to take:**

- Resident and family / representative will be consulted with and involved during illness and end of Life care.
- An MDT Approach will be used at times of illness and end of life care planning.
- Pain Assessments will be selected and used appropriate to Individual Service users.
- A programme of education for staff on End of Life Care will be planned.
- An occupational health first aid course will be provided to one staff member in each house.
- The ISBAR tool and Guidance for contacting the GP is revised and includes guidance on calling emergency services.
- All residents will be facilitated to have access to a spiritual advisor if they choose.

**Proposed Timescale:** 31/07/2016**Theme:** Health and Development**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents had not received annual medical reviews or appropriate health care assessments on a yearly basis. In addition; residents healthcare plans were not regularly updated following a medical review or as required.

**21. Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**

- Each Resident has access to GP & Nowdoc as required.
- Referrals are also made directly to some MDT members from Nursing Staff.
- A Rolling Schedule will be developed within each designated Centre for Annual medical reviews with GP. Commences in January of each year and continues on a rolling basis.
- Information received from Medical Staff / MDT Staff should be incorporated into Care Plans in a timely fashion.

**Proposed Timescale:** 31/12/2016

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Residents did not have the opportunity to purchase or cook their own food. The delivery of food from a centralised kitchen was found to limited residents' opportunity to choose what food they would like to eat.

Residents had only one hot meal option available at meal times.

**22. Action Required:**

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

**Please state the actions you have taken or are planning to take:**

- Environmental Health Officers & Catering officer are currently undertaking an assessment of all houses in this Designated Centre area to establish any health and safety concerns they may have around use by residents of kitchen areas
- The CNM's/ PIC's in consultation with Parents and Friends Association (owners of this Designated Centre) to formulate a long term accommodation plan for the designated centre in relation to Kitchen areas.
- Through person-centred planning, service users will be supported on an individual basis to purchase their favourite foods and prepare simple meals
- Residents have a choice of two hot meals from the Canteen.
- Residents have a choice to have their meal in the Canteen.
- Easy-read menus have been developed and made available to service users in every house.

**Proposed Timescale:** 30/09/2016

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The person in charge of this centre did not display the experience, skills, or responsibility and competency required to manage the designated centre effectively having regard for the serious number of failings identified on inspection.

**23. Action Required:**

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.



**Please state the actions you have taken or are planning to take:**

- The Person-In-Charge (PIC) at the time of the inspection was experienced with the necessary qualifications and skills to act as a PIC. However, the PIC was not dedicated full-time to the designated centre. The PIC was functioning as a Director of Services for the network covering three (3) residential services and day services.
- The management structure of the designated centre was reviewed May 9th 2016 and a proposed Governance Framework was completed with a new structure of 4 Designated Centres rather than one with a CNM2 identified as the person in charge in each of the four designated centres. Four CNM2 s have been allocated to the four designated centres.
- New PIC's will be in place when all training specified by the inspector has been completed on the 17/06/2016.
- The Director of Services will be a Person participating in management.
- The Provider Nominee will hold weekly supervision meetings with the PPIM
- The PPIM will hold weekly Individual Supervision meetings with CNMS
- CNMS will hold supervision meetings on a monthly basis with Staff

**Proposed Timescale:** 24/06/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The person in charge was appointed manager for three designated centres; however, the inspectors were not assured that the Director of Services/PIC was effective in the governance, operational management and administration of the designated centre.

**24. Action Required:**

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**

- One person is identified as a Person in Charge for each Designated Centre.

**Proposed Timescale:** 30/06/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Management systems in place in this centre were inadequate. They did not ensure that the services provided were safe, appropriate to residents needs, consistent or effectively monitored.

**25. Action Required:**

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**

- Please see attached Governance Framework outlining the reconfiguration of the designated centre into 4 designated centres with a PIC identified for each and the Director of Services identified as the PPIM in order to ensure that the service provided is consistent and effectively monitored.
- A review has taken place of the compatibility of residents sharing accommodation and a plan is in place to suitably relocate residents within the service to ensure the service provided is safe and appropriate to residents' needs, to be completed on a phased transition.
- There will be 3 monthly unannounced provider visits and reports of same will be forwarded to HIQA
- The Provider Nominee will meet with PIC's following inspections to discuss required action plans and agree dates for completion of same.
- There will be annual provider visit to the Centres and reports of same forwarded to HIQA

**Proposed Timescale:** 31/07/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no annual review of the quality and safety of care and support provided in the designated centre.

**26. Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

**Please state the actions you have taken or are planning to take:**

- An annual review of the quality and safety of care and support provided in the designated centre will be completed by the 30 July 2016 by the registered provider.

**Proposed Timescale:**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The registered provider failed to carry out an unannounced visit to the designated centre at least once every six months and prepare a written report on the safety and quality of care and support provided in the centre.

**27. Action Required:**

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**

- The registered provider will conduct an unannounced visit to the designated centre at least once every three months and prepare a written report on the safety and quality of care and support.

**Proposed Timescale:** 30/06/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

1. The deployment of staff required review to ensure that residents healthcare and social care needs are met.

**28. Action Required:**

Under Regulation 15 (1) you are required to: 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.

**Please state the actions you have taken or are planning to take:**

- Please see attached Governance Framework.
- The Keith Hurst Dependency Assessment has been completed for all service users to inform Staffing levels.
- The four designated centres will have a statement of Purpose which will reflect the new configuration of service delivery within this Designated Centre and will be forwarded to HIQA on completion.

**Proposed Timescale:** 30/06/2016

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The relocation of staff between houses on a daily basis was found to be negatively impacting on residents' outcomes and limiting the continuity of care and support provided.

**29. Action Required:**

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**Please state the actions you have taken or are planning to take:**

- See attached Governance Framework.
- A review of all existing staff rosters and skills mix has been completed
- The responsibility for the staff rosters will be devolved to the PIC for each designated centre to ensure continuity of care and support.
- Rosters are being completed by CNM's/PIC's will be in place by 20th June, 2016.

**Proposed Timescale:** 30/06/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The staff roster did not accurately reflect the staff on duty in each house and was not properly maintained by the person in charge.

**30. Action Required:**

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**

- An allocation of staffing has been identified for each designated centre 11.05.2016
- Each PIC will have responsibility for maintaining the planned and actual roster in each designated centre and ensuring the required staff /skill mix are rostered.
- The Director of Services will monitor staff rosters to ensure Regulation 15 (1) is met.

**Proposed Timescale:** 20/06/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The required schedule 2 documents were not present in the staff files inspected. For example; contracts of employment, two references, vetting disclosures or qualifications were not available.

**31. Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

**Please state the actions you have taken or are planning to take:**

- This is being reviewed in conjunction with the HSE Personnel Department. This process has commenced all staff documents will be in place by 30th September 2016.

**Proposed Timescale:** 30/09/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Many staff did not have access to mandatory training such as protecting vulnerable adults, safe moving and handling, managing behaviours that challenge, fire safety management, and epilepsy management training.

**32. Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**

- Personal development planning will commence for all Staff.
- A Training Needs Analysis has been completed to formulate staff training.
- A rolling schedule for refreshers in mandatory training will be developed and maintained by CNM's/PIC's.
- CNM's/PIC's will be responsible for ensuring staff attend training.
- Director of Services will conduct a quarterly audit to ensure identified training is sourced and staff have attended accordingly.

**Proposed Timescale:** 30/09/2016