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:	Railway View & Finnside
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Short Notice Announced
Date of inspection:	14 April 2021
Centre ID:	OSV-0005488
Fieldwork ID:	MON-0032457

About the designated centre

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

Railway Finnside Service provides 24 hour full-time residential support to both male and female residents who have an intellectual disability, some of whom have co-morbidity and complex behaviours of concern. Residents living in this service had very high clinical and nursing support requirements. The centre can accommodate 12 adults and comprises of two detached bungalows which are located on a small campus based setting. The campus is within walking distance to a town in Co. Donegal. There are six bedrooms in each house and all residents have their own bedroom. Both bungalows have considerable collective space and spacious gardens. The centre is staffed on a 24/7 basis with a full time person in charge (who is a clinical nurse manager II), and a team of staff nurses and health care assistants support the residents in their activities of daily living. The staffing arrangements include four staff on duty each day in one house and five staff in the other house. There are two staff on night duty in Railway View and three staff on duty in Finnside house in the centre. Access to GP services and other allied health care professionals form part of the service provided to the residents. There is a centralised kitchen on the campus from which meals are provided to the residents. There is also a day service where residents can attend (this was closed at the time of this inspection in response to COVID-19 restrictions).

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 14 April 2021	10:00hrs to 16:45hrs	Thelma O'Neill	Lead
Wednesday 14 April 2021	10:00hrs to 16:30hrs	Angela McCormack	Support

What residents told us and what inspectors observed

On the day of the inspection, there were nine residents residing in the centre, five residents in Finnside, and four residents living in Railway View. As this inspection took place during the COVID-19 pandemic, inspectors spent time reviewing documentation and meeting with the person in charge and staff in a room on the campus, where physical distancing could be easily maintained. Inspectors did get the opportunity to meet with the nine residents who lived in the two houses during the inspection, one inspector visited each house and spoke with staff who were familiar with residents' needs and could give an account of what residents' experiences were of living in the centre.

Residents were observed in the centre at dinner time and while relaxing in the living room in the afternoon. Staff interactions with residents were observed to be warm and caring. The premise formed part of a campus based setting and it was observed to be clean and the residents' bedrooms were generally personalised and decorated to the residents likes and wishes.The houses had nice outdoor areas with garden furniture, and this area was accessible from a few areas of the house where there were double doors. One inspector was informed that a resident had been out for a walk earlier in the day, and that one resident was having a family member visit in the afternoon. Residents living in this centre had very high nursing support needs and some also had complex behaviours of concern.

Inspectors also met and spoke to eight staff on duty. Staff spoke with inspectors about each of the house's daily routines and the impact the COVID-19 pandemic has had on the lives of the residents.

On arrival at Finnside, the inspector was told that one of the residents was self-isolating, as they had recently been discharged from hospital. The inspector agreed to follow the centre's infection control procedures including physical distancing, limiting time spent with residents and avoid entering the area where the resident was self-isolating. The inspector also wore a face mask and maintained hand hygiene. The inspector was told by the nurse that all staff were currently wearing full PPE while caring for the resident who was self-isolating and a two hourly changeover of staff was maintained daily for this resident. However, the inspector observed staff were not adhering to the guidelines outlined to them on arrival at the centre and when the inspector questioned the two staff on the procedures they were following, the care staff were unaware of the centre's Infection Prevention and Control practices (IPC) to wear full PPE while caring for the resident. On discussion with the person in charge, she confirmed to the inspector that the centre was not following the PPE recommendations of the HPSC guidance on the Infection prevention and Control procedures (IPC) for residents returning from hospital, and the inspector found there was no IPC risk assessment completed as recommended in the HPSC guidance, and included in the COVID-19 management plan for the centre. Furthermore, there was not clear guidance available to staff on the infection prevention and control procedures to be followed to prevent the potential spread of

the COVID-19 virus in the centre.

Inspectors observed the residents eating their dinner in both houses at 12.30pm. In Finnside, meals served to residents were observed from a distance and the food the residents were eating looked appetising and wholesome and all the residents appeared to enjoy their meal. Three staff were supporting residents with their meals. However, on review of residents' food diaries, it was noted that one resident who was assessed as a high risk of choking was not provided with the appropriate food or supports to ensure their risk of choking was kept to a minimum. The resident had been assessed by the Speech and Language Therapist (SALT), to only eat a specialised texture B mince moist diet due to their high risk of choking, and they also recommended the resident eat only while sitting in an upright position in their wheelchair. However, the inspector observed in the resident's food diary, that they were regularly given food for their evening meal that was identified in their Feeding Eating and Drinking (FEDS) assessment as not suitable and a choking hazard. Staff told the inspector that there was no specific texture B food options provided for residents on specialised diets for the evening meal, as the food was provided by a centralised kitchen on the campus.

The inspector also saw evidence in the resident's nursing notes that the resident was not supported to sit in their wheelchair for their meals, as recommended by the SALT and the resident had experienced a choking incident the week previous while eating their breakfast in bed. Staff told the inspector that the resident was given their breakfast in bed in the mornings, as there was a lack of manual handling equipment available in the house and they did not want the resident to be hungry in the mornings. Therefore the inspector found the residents' care and support needs were not being adequately met in line with their care and support needs. These risks were brought to the attention of the person in charge during the inspection.

The inspector also found that the resident had become a full-time wheelchair user in 2018 due to a number of falls at the centre. On review of the nursing intervention notes, it advised that the resident was prescribed a 30 minute daily exercise programme by the physiotherapist, to maintain their core muscle strength. However, staff confirmed this exercise regime,had not been maintained, as there had not been a consistent staff team working in the centre to implement the physiotherapy programme, and consequently the resident had lost their muscle strength and their ability to move their legs independently or weight bear since they stopped walking. The resident now required full hoisting with the support of two staff.

The inspector also found the resident's nursing care notes, gave conflicting information, regarding their nutritional care needs, particularly the need for a daily fluid restriction to be monitored for this resident. One nursing care note stated the resident's fluid allowance was set at 1,500mls another intervention plan stated it was 1,200mls per day; however, on discussion with the relief staff nurse on duty in the centre they confirmed the resident was not on a fluid restriction plan at all, and they were not aware of this nursing intervention plan in the resident's notes. Inspectors found this conflicting information could impact on the health of the resident, and pose a risk to the residents of different staff implementing different

care practices.

The inspector also found one of the resident's had become totally blind since March 2021 following an incident of self- injury in February 2021. Nursing records showed the resident was reviewed at the hospital eye clinic in March 2021 and the doctor diagnosed a serious eye injury and recommended surgery to repair the damage. However, the resident did not have the surgery, and there was no care plan details in the resident's nursing or medical notes and staff caring for the resident did not have any details of when this surgery was to occur or if, this surgery would occur. Staff told the inspectors that the resident was distraught at the loss of their sight and could no longer walk around the centre independently, they could not see their their food on their plate and had lost interest in food, and could no longer watch their favourite programmes on television.

Furthermore, the same resident was waiting on a follow-up medical appointment for another medical procedure following a recommendation of a hospital consultant in October 2020, but no follow-up appointment or notes relating to this follow-up investigation was documented in the resident's file either. Staff told the inspector they were worried about the resident's deterioration in health, as they were no longer eating and appeared unwell. This was brought to the attention of the person in charge on the day of the inspection, who agreed to follow-up on the issue.

Inspectors found although there was adequate staff working in the centre, they were not all familiar with the care and support needs of the residents, in Finnside, two staff were core staff and the other three staff were relief or agency staff. The inspector also found the management of emergency medication administration required review, as only staff nurses were trained to administer medication in this centre, which had negatively impacted on a resident, when they had an epilepsy seizure and there was no staff nurse present in the centre to administer the medication as prescribed.

The inspector took a walk around the premise in Finnside and observed that the kitchen was very small, and residents who were wheelchair users had restricted access to their kitchen due its design and layout. Furthermore, inspectors found the centre did not promote person-centred care, as residents were not given the opportunity to participate in shopping for food or cooking their meals, as the food was all prepared, cook and delivered from a centralised kitchen.

Inspectors also observed when walking around the building that one resident's bedroom had a ceiling hoist. This resident also had access to the main bathroom from their bedroom, and while there were ceiling hoists in both rooms, both hoists were out of order for a number of months. In addition, the resident could not access the bathroom via their bedroom using the ceiling hoist, as the two ceiling hoists were not appropriately aligned. Staff told the inspector that these manual handling issues were negatively impacting on the resident's quality of life, as the number of manual transfers had increased, because the ceiling hoists were not working properly. In addition, another resident had also been waiting several months for a ceiling hoist to be installed following a physiotherapist recommendation in October 2020 which stated that the design and layout of their room was not suitable for the

use of a manual hoist, the ceiling hoist had not been installed on the day of inspection and no date for its installation was in place. Due to issues relating to the availability of a overhead ceiling hoist, only one manual hoist was available for all residents at the house, as the second manual hoist was also broken.

Inspectors were told that most residents would be unable to speak to them about their daily lives or day-to-day routine. In Riverside, one resident that could communicate verbally was having a nap in their chair in the afternoon and was therefore not disturbed by the inspector. Staff told the inspector that the residents had activities provided for them from home, and some residents liked going on the bus for a drive, watching television, going for walks and going out to the polytunnel in their garden. The inspector saw in the residents' daily notes, that social activities were very limited and there was limited social activities occurring in the centre.

The inspector found the day-to-day routine of the centre was very institutional and the practices and systems in place did not lend themselves to promoting a person-centred or rights-based approach to meeting residents' needs. For example, the service was not sufficiently responding to the individual needs and wishes of residents, but rather the set routine of the centre especially around meal times. For example, the inspector was told by staff that all residents were usually up in the morning by 10.30 am, dinner was served at 12.30pm, staff lunches started at 1.00pm up to 2.30pm, two residents returned to bed for a rest and other residents relaxed in the living room or participated in some social activities until 4.30pm when evening tea was served. A staff member told the inspector, that the residents who get up between 10.00 and 10.30 am are generally not hungry for dinner at 12.30pm and frequently refuse dinner. They suggested it would be better for the residents in this centre, if they could plan their dinner time on a daily basis, so the residents could have more choices around their daily routines, and staff could assist residents to do more social activities during the day and be back in the evening for the dinner if they so wished.

Staff told the inspectors that they had gone through a very difficult time in January 2021 where the house was in 'lock down' due to suspected and confirmed cases of COVID-19 and one resident had passed away as a result.. The nurse told the inspector about the difficulties of caring for the residents during the pandemic and the trauma COVID-19 had caused for both residents and staff, especially relating to the bereavement. It was clear from talking to the staff, that residents are very respected and provided with care and dignity at the end of their life in the centre, even when managing staff shortages at the centre during the pandemic.

One inspector visited Railway View and got the opportunity to meet briefly with all four residents and three staff members while adhering to the wearing of masks and social distancing. One resident had just finished their lunch and greeted the inspector in their own terms. The resident led the inspector to the visitor room and was supported by staff in line with their assessed needs of requiring 1:1 staff support. The resident became upset while in the visitor room and wept. They did not communicate with the inspector about what was upsetting them, and the inspector tried to reassure them by acknowledging that they were feeling upset. The resident was reassured by the staff supporting them when staff spoke about things

that the resident liked to do, such as going to the park and visiting the graveyard. This intervention appeared to support the resident to feel better, and later the resident was observed to be sitting in the communal area with their peers and staff.

Prior to the inspector leaving, they got the opportunity to meet with another resident who had been reported to be relaxing in their bedroom. They came up to the dining area and greeted the inspector by smiling, and they were observed to be relaxed while choosing to sit at the table with another peer. The house appeared bright, clean, homely and was nicely decorated.

Overall, inspectors found that residents' experiences of the care and support they received differed depending on what house within the centre they lived in, although improvements were required across both parts of the designated centres and in its overall governance and management. The next sections of the inspection report will discuss more in depth the centre's governance and management arrangements in and how these impacted on the quality of care and support provided to residents.

Capacity and capability

The provider of this service is the Health Service Executive (HSE), however although there were clear governance structures in place at the centre they did not ensure the service provided was a safe and effective for all residents.

A person in charge was responsible for managing the day-to- day operations of the centre, however, inspectors found that the manager had not effectively identified and subsequently ensured that residents' care and support needs were met at all times.

The centre was found to promote a culture of institutional care practices, as there was no flexibility in the day-to-day routine for residents. In addition, there was no consistent staff team and a reliance on numerous relief and agency staff work in the centre on a weekly basis. Service delivery was centred around organisational routines such as, meal times and the availability of staffing in the centre.

A significant number of risks were identified in the centre associated with residents' care needs, particularly as described earlier in this report around residents' health needs, access to aids and adaptations , the availability of suitability trained staff a and access to multi-disciplinary professionals such as speech and language therapists and behaviour supports. Furthermore, the provider had not ensured that there was effective arrangements in place to support, develop, and performance manage all staff members to ensure they were fully able to exercise their professional responsibility for the quality and safety of the services they were delivering.

On the day of the inspection there were nine staff working in the centre during the day, and four staff at night. Inspectors found that the provider had ensured that the number, qualification and skill mix of staff working in the centre were suitable to meet the care and support needs of the residents. However, there was no consistency in the staff team, as there continued to be an over reliance on agency and relief staff from other designated centres within the campus to cover staff leave. These staff were not appropriately inducted and trained to attend to all of the residents' health and social care needs and goals. In addition, staff working in the centre were frequently required to support residents and staff in other designated centres on the campus, for example, to drive the bus, or provide support to other houses when staff went on appointments, or outings, which affected the continuity of care for the residents in this centre. These types of issues was also identified and actioned on the last inspection and had not yet been addressed.

Inspectors also found staff were not aware of the COVID-19 infection control procedures following a resident's discharged from hospital and also staff did not have up-to-date training as required by the provider and in line with residents' assessed needs. For example, positive behaviour management training had not been provided for all staff and two staff had not received 'Children First' training. Also following the inspection ,the inspectors were informed that the provider had not implemented recommended additional safeguarding of vulnerable adults training for all staff in areas such as sexual expression, and the management of related behaviours of concern.

Inspectors also found that the provider did not ensure residents had access to Speech and Language Therapist (SALT) services, and were not supported to access assistive technology and aids and appliances as required. Inspectors noted that this was a long standing action in the centre's organisational 'Quality Improvement Plan' (QIP) and was also highlighted in the centre's risk register, but no progress had been made by the provider to address this need.

The provider had systems in place to monitor and review quality and safety and risks in the centre and had completed an annual review and two six monthly unannounced audits of the centre. However, inspectors found that the provider's auditing systems were not robust in terms of identifying risks and operational and management issues, and they were not effective in addressing practices which required improvement at the centre.

Regulation 15: Staffing

There was not a consistent staff team in the centre. There was a high level of relief staff working in the centre and moving between houses in the centre. This impacted on the continuity of care and support provided to residents. The staff rosters were not always reflective of the staff changes occurring in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place were not comprehensive in nature and did not ensure the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored. In addition, the provider had not ensured there was effective arrangements in place to support, develop, and performance manage all members of the workforce to exercise their professional responsibility for the quality and safety of the services they are delivering.

Judgment: Not compliant

Quality and safety

Inspectors found the quality of care provided in the centre was dependent on which house the residents resided. Overall, the inspectors found residents well-being and welfare were managed more effectively in one house, whereas significant improvements in the management of individual assessments and personal plans, health care, food and nutrition, risk management, infection prevention and control, premises and staff training were identified in the other house within the centre.

Inspectors found improvements were required in residents' individual personal plans to ensure they reflected the actual care required and delivered to residents. The personal plans did not reflect the changing needs of the residents and multi-disciplinary recommendations were not implemented. There was also no evidence that the resident or their representatives were involved in the care planning process.

The management of behaviours of concern required review, as there was not clear guidance for staff on how to manage incidents of concern, such as self-injury, also staff did not have training in positive behaviour support.

The centre did not have adequate systems in place to manage the high level of risks in the centre, including an effective system for responding to emergencies. These included the management of choking risks, manual handling risks, medication management risks and pressure care risks. In addition, food provided to residents was not consistent with each residents' dietary needs

Inspectors found urgent medical treatment that was recommended and agreed by the resident, was not facilitated, and there was no plan in place to identify the plan of care for this resident. The provider did not facilitate residents access to allied health services as and when required, or implement allied health professional recommendations as required. For example; residents were not facilitated to access

assistive technology and aids and appliances as recommended by the Speech and Language therapist.

The design and layout of the centre did not meet the aims and objectives of the service. Residents could not access their kitchen due to its small size and no adaptation had been made to promote access for wheelchair users. Also manual handling equipment was not provided to residents in line with their assessed needs and other moving and handling equipment was not maintained in good working order and repairs were not carried out as quickly as possible, so as to minimise disruption and inconvenience to the residents.

Staff were trained in safeguarding policies and procedures and where concerns of a safeguarding nature were identified, these were followed up in line with the safeguarding procedures. However, following the inspection, the inspector was informed by the provider that they had not implemented recommended staff safeguarding training in the areas of sexual expression.

Furthermore, residents' rights were not promoted in the area of personal finances. As although they had access to personal monies held at the centre, they did not have access to information on their total financial income, with only balances available on money held at the campus being provided, which impacted on their ability to make long-term plans.

Regulation 10: Communication

Residents were not facilitated to access assistive technology and aids and appliances as required.

Judgment: Substantially compliant

Regulation 17: Premises

The design and layout of the centre did not meet the aims and objectives of the service, as it did not promote accessibility to the kitchen to residents who were wheelchairs users. Also manual handling equipment was not provided to residents as recommended and and repairs were not not carried out as quickly as possible, so as to minimise disruption and inconvenience to the residents. Also, there was not adequate storage space in the centre to store residents equipment which had resulted in a vacant bedroom being used to store equipment.

Judgment: Not compliant

Regulation 18: Food and nutrition

Food provided to residents was not consistent with residents' dietary needs and recommended by multi-disciplinary professionals.

Judgment: Not compliant

Regulation 26: Risk management procedures

The management team did not have effective oversight of risks in the centre, particularly, the assessment and management of risks including putting in place an effective system for administering emergency medication when a nurse was not in the centre. In addition, the management of choking risks and access to appropriate food and nutrition, manual handling risks, falls risks, and the risks of not implementing exercise programmes to maintain residents physical strength.

Judgment: Not compliant

Regulation 27: Protection against infection

Staff did not effectively adopt procedures consistent with HPSC guidelines for the management of COVID-19 in the centre. For example; Staff were not clear on the appropriate infection control procedures for COVID-19 in the centre. The inspector found staff were not following the HPSC guidance in terms of the use of PPE for a resident that was restricting their movement on return from hospital. A risk assessment on the management of the residents care was not documented and communicated to staff. The management of this risk had negatively impacted on the staffing levels in the centre, and the care and support provided to all residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge did not ensure that residents individual personal plans were accurate and reflected the actual care delivered to residents. The personal plans also did not reflect the changing needs of the residents and multi-disciplinary recommendations were not implemented. There was also no evidence that the resident or their representatives were involved in the care planning process. For example; residents care plans did not direct the provision of care for one resident

that had recently become totally blind. Also the management of a resident requiring pressure care management was not clearly documented in the residents file, and documentation give conflicting advice on the need for a fluid restriction and when discussed with staff, the resident was not on a fluid restriction.

Judgment: Not compliant

Regulation 6: Health care

Inspectors found that medical treatment that was recommended and agreed by the resident had not been facilitated or followed-up on by staff, and there was no long-term plan to address the resident's need while awaiting treatment. Residents' health plans were not consistently followed resulting in their needs not being met, with some plans not correctly reflecting the assessed needs of the residents. Furthermore, arrangements in place at the centre did not provide assurances that access to recommended allied health care professionals was facilitated, or agreed health recommendations were consistently implemented.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The management of behaviours of concern required review, as there was not clear guidance for staff on how to manage incidents of concern, such as self-injury, also staff did not have training in positive behaviour support.

Judgment: Substantially compliant

Regulation 8: Protection

Staff were trained in safeguarding policies and procedures and where concerns of a safeguarding nature were identified, these were followed up in line with the safeguarding procedures. However, following the inspection, the inspector was informed by the provider that they had not implemented recommended additional safeguarding training in the areas of sexual expression for all staff.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors found that residents' daily routines were directed by institutional practices at the centre, rather than their individual care and support needs. For example, residents morning routine was based around the availability of equipment and staffing. Furthermore, residents were unable to make long-term plans based on their financial income, as they were only provided with financial statements relating to monies held at the campus. Residents were also prevented from having access to all parts of the centre due to its design and layout such as the kitchen and dining area.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Railway View & Finnside OSV-0005488

Inspection ID: MON-0032457

Date of inspection: 14/04/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to bring this centre into compliance the following actions will be taken: 1. Each house has a dedicated staffing cohort allocated. The Person in Charge completes the roster for the centre from this staffing cohort. Staff from the centre staffing cohort is used for cover purposes. 2. The Director of Nursing and the Provider Representative has designed a standalone roster for the centre to provide a dedicated and consistent staff cohort. 3. The Director of Nursing, the Provider Representative and the Human Resource Department has commenced consultation and engagement with staff representative bodies regarding the implementation of the new roster. Engagement commenced on 30.04.2021. The new roster will be implemented by 31.07.2021.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to bring this centre into compliance, the following actions will be taken: 1. The Governance of the Centre and the Person in Charge has been supported by the appointment of a Clinical Nurse Manager 1. 2. An alternative cover system has been put in place in the event that the Director of Nursing is on leave. Senior Cover will be provided by a Director of Nursing or Area Co-ordinator from another service area.	

3. The Provider Representative arranged for the Nurse Practice Development Team to complete an audit of all residents' medical and personal files in the centre. The audit focused on Care Provision in specific areas such as Healthcare, Nutrition, Epilepsy, Nursing Interventions and Nursing Documentation. A draft report was provided to the Director of Nursing and Person in Charge 8.06.2021. On receipt of final audit report, the Person in Charge will meet with each Named Nurse to discuss the outcome of the audit and agree a time bound action plan which will be monitored on a weekly basis by the Person in Charge and Clinical Nurse Manager 1. Corrective action will be taken where progress is not being achieved. Completion date 11.07. 2021.
4. A more robust daily report and handover process was implemented in the centre from 4.05 2021.
5. The Director of Nursing and Person in Charge met with the Catering Manager and the Chef on 28.04.2021 and completed a review of menus. Update on the dietary needs of each resident has been provided to the Chef. The menu order system has been reviewed to ensure that kitchen staff has clarity in relation to each residents recommended dietary intake arrangements.
6. The Director of Nursing has scheduled a Performance Achievement meeting with the Person in Charge for 11.06.2021. The Person in Charge has developed a schedule for completion of Performance Achievement meetings will all staff working in the centre.
7. A schedule of bi- monthly governance meetings is in place in the centre where staff are afforded the opportunity to raise any concerns they may have in relation to the quality and safety of care and support provided in the centre in order for these to be addressed in a timely manner. These will commence from 14.06.2021 and will be completed by 31.08.2021.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication: In order to bring this centre into compliance, the following actions will be taken:

1. A private Speech and Language therapist has been working with one resident since 09.04.2021. SALT training has been provided to staff working in the centre on 30.04.2021 and 27.05.2021. Further training will be arranged as required with the Speech and Language therapist.
2. A Picture Exchange Communication System has been implemented for one resident since 30.04.2021. There is ongoing monitoring of this system by the Person in Charge and the Speech and Language therapist.
3. The Person in Charge reviewed and updated the Centre's Risk assessment and Quality Improvement Plan to reflect that the Speech & Language Assessment had been completed on 9.4.2021. A dedicated resource of 0.3 wte SALT for an initial six month period has been approved for residents who require SALT intervention.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to bring this centre into compliance, the following actions will be taken:

1. Residents are being supported by staff to prepare simple meals in their home if they wish to do so using the dining room which provides a more accessible space.
2. HSE Estates will carry out a preliminary review of the design and layout of the centre's kitchenette, utility and dining area and develop options to reconfigure the centre to ensure it meets the aims and objectives of the service and promotes the full capabilities and independence of residents in choosing, preparing and cooking meals of their choice.
3. The Disability Services Manager as Provider Representative and the Director of Nursing will engage with the Housing Association to discuss and gain agreement on proposed options to adapt the layout of the centre further to review by Estates. This will be completed by 30.06.2021
4. There are two functioning manual hoists and one functioning overhead tracking hoist available in the centre for two residents who are assessed as requiring same for safe transfers.
5. A further overhead tracking system has been approved for installation with a completion date of 30.06.2021.
6. A servicing contract is in place for all manual handling equipment and records are maintained in the centre of all works completed. A protocol for the timely reporting of maintenance issues has been communicated to all staff working in the centre.
7. A risk assessment has been completed by the Person in Charge for storage space in the centre. Alternative arrangements have been put in place to facilitate safe storage of equipment. A further review will be completed by the Occupational Therapist and Physiotherapist on 14.06.2021.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
In order to bring this centre into compliance, the following actions will be taken:

1. A review of food diaries has been completed in conjunction with the Nurse Practice Development Team and changes recommended will be communicated to all staff and implemented by 18.06.2021
2. The Director of Nursing and Person in Charge met with the Catering Manager and the Chef on 28.04.2021 and completed a review of menus. Update on the dietary needs of each resident has been provided to the Chef. The menu order system has been reviewed to ensure that kitchen staff has clarity in relation to each residents recommended dietary

intake arrangements.
3. All staff working in the centre will complete training on Dysphagia by 15.07.2021.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to bring this centre into compliance, the following actions will be taken:

1. A risk assessment has been completed for administering emergency medication when a nurse is not in the centre. An additional control identified training for health care staff. This training is scheduled to be completed by 30.06. 2021.
2. The Provider Representative arranged for the Nurse Practice Development Team to complete an audit of all residents' medical and personal files in the centre. The audit focused on Care Provision in specific areas such as Healthcare, Nutrition, Epilepsy, Nursing Interventions and Nursing Documentation. A draft report was provided to the Director of Nursing and Person in Charge on 8.06.2021. On receipt of final audit report, the Person in Charge will meet with each Named Nurse to discuss the outcome of the audit and agree a time bound action plan which will be monitored on a weekly basis by the Person in Charge and Clinical Nurse Manager 1. Corrective action will be taken where progress is not being achieved. Completion date 11.07. 2021.
3. Each Named Nurse has commenced a review of each residents risk areas to ensure these have been identified and that effective measures are in place to mitigate each risk. These will be reviewed by the Person in Charge. This action will be completed by 23.06.2021.
4. All Nursing Staff will complete a refresher course on Risk Management procedures by 30.06.2021

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
In order to bring this centre into compliance, the following actions will be taken:

1. A COVID-19 response and contingency plan is in place in the centre which provides clear guidance to staff on the appropriate Infection Control procedures in the centre.
2. The Person in Charge revisited the HPSC guidance with staff to provide total clarity on

the correct implementation of Infection Control procedures within the centre.
3. A risk assessment has been completed and communicated with staff on the management of residents' care following acute hospital admission. This was completed 19.04.2021

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
In order to bring this centre into compliance, the following actions will be taken:

1. The Provider Representative arranged for the Nurse Practice Development Team to complete an audit of all residents' medical and personal files in the centre. The audit focused on Care Provision in specific areas such as Healthcare, Nutrition, Epilepsy, Nursing Interventions and Nursing Documentation. A draft report was provided to the Director of Nursing and Person in Charge on 8.06. 2021. On receipt of the final audit report, the Person in Charge will meet with each Named Nurse to discuss the outcome of the audit and agree a time bound action plan which will be monitored on a weekly basis by the Person in Charge and Clinical Nurse Manager 1. Corrective action will be taken where progress is not being achieved. Completion date 11.07.2021

2. Invitations are extended to each resident and their representative to attend their Annual Review of care and support provided. In the event that the resident or the representative cannot attend the review, the Named Nurse and Keyworker arrange discussions with the resident and their representative to ensure their views are represented at the annual review.

3.Refresher training has been arranged for staff working in the centre in Person Centred Planning. This training will be completed by 31.07.2021.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
In order to bring this regulation into compliance, the following actions will be taken:

1. Where appointments are delayed or not facilitated in a timely manner, a review with the General Practitioner will be completed with a view to arranging a private consultation. This measure has been put in place since 30.04.2021.

2. A more robust daily handover process has been implemented in the centre with effect from 4.05.2021 to ensure that timely follow up is managed, monitored and communicated to all staff.

3. A Named Nurse is allocated to each resident and Named Nurse responsibilities have been revisited with all Nurses working in the centre on 21.04.2021

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In order to bring this regulation into compliance, the following actions will be taken:

1. A dedicated allocation of 0.5 wte Psychology is allocated to Ard Greine Court for an initial six month period and will be reviewed thereafter.

2.A Clinical Nurse Specialist for Behaviours of Concern development is being progressed and the post holder will initially be assigned to Ard Greine Court on a 0.5 WTE basis with review in six months. In the interim a Clinical Nurse Specialist for Behaviours of Concern is being provided on a consultative basis with onsite visits to Ard Greine Court for a six month period.

3.A Review of residents behaviour support plans, crisis management plans and restrictive reactive strategies has been completed by the Named Nurses in conjunction with the Person in Charge and the Clinical Psychologist to ensure all possible behaviour triggers are identified and to provide staff with clear guidance on how to consistently respond and support residents. Multi-disciplinary team members who support the resident were also involved in the review of plans. Plans are reviewed ongoing as and when changes in behaviours or new behaviours arise and indicate that a review of the existing plans and strategies is required.

4. A schedule has been put in place for staff to complete training in positive behaviour support. 31.08.2021

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

In order to bring this centre into compliance, the following actions will be taken:

1. A robust overarching Safeguarding plan has been developed and implemented for each resident in the centre. This was completed 30.04.2021
2. The policy on Supporting Sexuality in Supported Settings for Adults who have an Intellectual Disability will be rolled out in the centre. Policy implementation will be supported by the delivery of sexuality awareness training in supported settings. 31.08.2021

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
In order to bring this regulation into compliance, the following actions will be taken:

1. There are nine staff on duty in the centre on a daily basis supporting nine residents. Each resident is supported by staff in terms of their will, choice and preference. Documentation within the centre has been reviewed and updated to ensure that residents' preferences are recorded by staff on a daily basis to reflect their wishes.
2. Residents are supported to have their meals as they wish. There is a Bain Marie and microwave available in the centre to reheat meals when required. Alternative meals are prepared by staff in the centre. The food diary has been reviewed and updated to reflect residents will and preference in terms of choice and time of meal and alternatives provided.
3. Residents are being supported by staff to prepare simple meals in their home if they wish to do so using the dining room which provides a more accessible space.
4. There are two functioning manual hoists and one functioning overhead tracking hoist available for two residents who are assessed as requiring same for safe transfers.
5. A further overhead tracking system has been approved for installation with a completion date of 30.06.2021.
6. Quarterly financial statements have been provided to residents relating to monies held centrally in the Health Service Executive Patient Private Property Account. This was completed 22.04.2021

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 10(3)(b)	The registered provider shall ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.	Substantially Compliant	Yellow	30/04/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/07/2021
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in	Not Compliant	Orange	30/06/2021

	good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 17(5)	The registered provider shall ensure that the premises of the designated centre are equipped, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.	Not Compliant	Orange	30/06/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre	Not Compliant	Orange	30/06/2021

	to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2021
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Not Compliant	Orange	15/07/2021
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	31/08/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/08/2021

Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/08/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	11/07/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare	Not Compliant	Orange	19/04/2021

	associated infections published by the Authority.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/07/2021
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.	Not Compliant	Orange	04/05/2021
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	04/05/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in	Substantially Compliant	Yellow	31/08/2021

	the management of behaviour that is challenging including de-escalation and intervention techniques.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	31/08/2021
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	31/08/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/06/2021
Regulation 09(2)(e)	The registered provider shall	Not Compliant	Orange	30/06/2021

	ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.			