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:	Dunwiley & Cloghan
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Short Notice Announced
Date of inspection:	16 March 2021
Centre ID:	OSV-0005489
Fieldwork ID:	MON-0031963

About the designated centre

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

Dunwiley and Cloghan is registered to provide full-time residential care and support for up to ten male and female adults. The designated centre comprises of a six bed bungalow and a four-bed bungalow. Although the centre has a registered bed capacity for up to ten beds, the centre currently has a vacancy for two beds and provider has taken the decision to only use eight beds in the centre, due to incompatibilities of residents in the centre. The centre is located within a campus setting which contains three other designated centres operated by the provider. The centre is located in a residential area of a town in Co. Donegal and is in close proximity to amenities such as shops, leisure facilities and coffee shops. There is transport available for residents to travel to appointments or shops if they wish. Residents are supported by a staff team of both nurses and care assistants. During the day, support is provided by seven staff (five in one bungalow and two in the other). At night residents are supported by two staff members in each bungalow. Nursing care is provided on a 24/7, basis meaning a nurse is allocated in each bungalow during the day and at night. The person in charge has a dual role and is also responsible for one other designated centres as well as being the Acting Director of Services for the whole campus. She is supported by a Clinical Nurse Manager 2 who is full time and is responsible for both houses in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Tuesday 16 March 2021	10:00hrs to 17:00hrs	Thelma O'Neill	Lead
Tuesday 16 March 2021	10:00hrs to 17:00hrs	Angela McCormack	Support

What residents told us and what inspectors observed

Inspectors found that residents living at Dunwiley and Cloghan had a poor quality of life, because of risks arising due to incompatibility of residents living together and their assessed needs not being met. Through observations, reviews of documentation and discussions with staff, inspectors found that there was a high level of behaviours of concern and safeguarding incidents at the centre which were not effectively managed and significantly impacted on the quality of care received, and safety of residents at the centre.

Inspectors got the opportunity to meet with five residents and five staff during the inspection. The inspectors visited one bungalow each where they met with residents and staff while adhering to the public health guidance of physical distancing and the wearing of face masks. There were eight residents living between the two locations, however, one resident was reported to be in hospital on the day of the inspection, while one other resident was away for the day and another had chosen to spend their time sleeping in their bedroom. As well as speaking with staff and residents, inspectors also had the opportunity to observe some of the interactions between residents and staff when in the centre.

In one bungalow, the inspector met two residents in the hallway and during the interaction, they began to vocalise loudly towards each other, with staff telling the inspector that one of the residents had insulted the other. Also during the visit, one resident told the inspector that they felt unwell and asked them to call a doctor. Staff told the inspector that the resident had medical investigations for the described issue previously, which had not found anything of concern. However, the inspector later noted following a review of the resident's healthcare records, that the resident had progressively been losing weight, as their weight records showed that they were nine kilograms under their recommended weight. It was further noted that a referral had been made for a dietician assessment in January 2021, and the resident was awaiting an appointment date.

The inspector also spoke to three staff members working in the centre. The three staff had only recently in the last two weeks been redeployed to the centre, with two of the staff being unfamiliar with the residents' care and support needs. The third staff member (a staff nurse) had worked in the centre previously and it was clear that the residents were very comfortable with them, as they kept by his side when he was doing household chores. Due to residents' behaviour-related needs, the inspector also observed the nurse chatting with residents and using distraction techniques to move residents away from each other due to possible incidents occurring between them. The nurse also showed the inspector briefly around the centre, and asked another resident who was in bed if they wanted to speak to the inspector and they said 'No', but did say 'Hello' to the inspector who was standing in the hallway.

In the other bungalow, an inspector met with two residents and two staff. The

inspector was shown a sitting-room where it was said that one resident would use this room as their own space to listen to music. The room was nicely furnished; however some aspects required repair such as a broken window blind.

One resident was finishing a meal in the kitchen area as the inspector arrived, and staff invited the inspector to meet them. The resident communicated to the inspector about their family members and music equipment they enjoyed, and staff were observed to be responsive to their communications. The inspector did not get the opportunity to spend much time with the resident as they appeared to get upset during this interaction, verbalising requests and engaging in self-injurious behaviour, therefore the inspector went outside to minimise the distress to the resident. Staff were observed to be supporting the resident by the use of distraction techniques in line with their behaviour support plan.

The inspector met another resident at the front of the bungalow, and they agreed to talk with them. They were supported by staff and were observed to be happy and comfortable with the staff support provided. They spoke briefly about things that they liked to do such as going out in the centre's bus, going to a respite centre for breaks and going on holidays. When asked, they said that their favourite thing about the centre was their bedroom and said they had a television of their own in the room. They told the inspector that they missed their day service, but also said they had been out in the bus for a drive that day.

While staff supporting residents were observed to treat residents in a respectful and dignified manner, it was noted that there was only one regular staff member out of the five on duty in one of the bungalows. Inspectors were informed that a number of staff were off duty for various reasons, and staff had, had to be moved from other locations in the campus to work in the centre because of behaviour management requirements. However, although the appropriate number of staff were available, this situation did impact on the continuity of care for residents with high support needs.

As part of the inspection, inspectors also reviewed a number of documents, including residents' support plans, daily care notes, incident reports, safeguarding plans, assessments of needs, person centred plans and food records. Records reviewed indicated that the quality and safety of care was poor, with some practices being institutional in nature such as meals being delivered from a centralised kitchen, which impacted on residents' rights and choices.

As part of the inspection, inspectors followed up on reported safeguarding concerns at the centre. Inspectors found that while safeguarding concerns and incompatibilities between residents had been identified, there had been little progress made to address them such as actions to safeguard the most vulnerable residents or implement appropriate control measures to prevent further incidents. This situation led to a poor quality of life for residents, with incidents of concern occurring almost daily at the centre, and impacting on residents' daily lives and their right to enjoy their home.

Due to the current public health restrictions, community activities at the centre were

limited; however, inspectors were informed and it was also noted in care notes, that residents' daily activities were often based around getting out of the house and away from their peers, due to the high level of risk behaviours occurring.

Inspectors found that there was little evidence of an ongoing commitment to support residents in identifying meaningful and individual goals for the future, and offering opportunities for individual activities and new experiences. A review of a personal plan for one resident identified goals for the future, and included a time frame of three months in which to achieve them. These goals included; making weekly phone calls to family, going to the shop for a take away beverage and listening to music of choice in their sitting-room. It was noted that two of these goals were activities included in the behaviour support plan to support the resident on an ongoing basis, which meant that the goals identified for the future were everyday activities and not developmental in nature.

In addition, inspectors noted that a goal had been identified for a resident to get more active to improve their physical and mental well being; however, a note was attached to the plan to say that this was postponed due to COVID-19. While it was acknowledged that the public health restrictions affected many community-based activities, there was little evidence that residents were supported to identify alternative activities to support this goal. In addition, one resident's family were noted to be very involved in their lives; however a review of the resident's annual review meeting did not include consultation with family members, therefore limiting opportunities to get views on what meaningful goals the resident might strive for.

In addition, a review of daily records indicated regular use of PRN medication to support a resident with behaviours of risk to themselves. While there was a behaviour support and crisis management plans in place, this failed to identify possible triggers to behaviours which were evident in their care notes. For example, care notes indicated that many incidents occurred around meal times and also when the resident requested specific food items, inspectors saw incidents of when the food requested by residents was not provided, incidents of concern occurred resulting the administration of chemical restraint. In addition, it was also not clear from the daily care notes or support plans, that alternative measures had been explored to ensure that chemical restraint was only administered as a 'last resort'. Furthermore, inspectors noted that on one occasion, when offered fruit, the resident's behavior had settled, but records did not show that this outcome had been reviewed as part of ongoing learning and review of the effectiveness of behavioural strategies nor was there evidence to show that limited food choices could be a possible trigger for the behaviours of concern.

Inspectors also found the resident had been assessed as requiring communication supports, however a communication support plan was not in place to enable them to express their needs more effectively. The need for appropriate supports around communication was required to enable residents to make choices and express themselves more effectively, which in turn may have lead to a reduction in incidents of behaviours of concern at the centre.

In summary, inspectors found that the centre did not operate a rights based

approach to care. It was evident through observations, conversations with staff and documentary review that residents living in both bungalows were not compatible based on their assessed needs. Residents were not given the appropriate supports to communicate or express themselves as outlined in their needs assessments, and their choices were not supported. This resulted in increased incidents of behaviours of concern which were harmful to themselves and others, and impacted on the care and support provided and overall atmosphere at the centre. In addition, despite the provider acknowledging the high risks at the centre, there was little progress made in addressing these issues to ensure residents' safety was promoted, and as a result residents continued to live in an environment where their daily lives, freedom to make choices and quiet enjoyment of their home were significantly impacted.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

On this inspection, inspectors found that the provider did not demonstrate effective governance and management arrangements to ensure a good quality of care and support for residents. Management arrangements for behaviours of concern were ineffective resulting in a high level of behaviour incidents at the centre which resulted in residents not being safe. Due to the level of non-compliance and concerns identified during the inspection, a decision was subsequently made to issue a warning letter to the provider by the Chief Inspector of Social Services to ensure improvements occurred at the centre to safeguard residents and bring the centre into compliance.

The provider was aware of the incompatibility of residents' needs and the high level of challenging behaviour incidents at the centre, with this being identified through their own risk management processes since January 2020. The level of risk at the centre was further highlighted as part of the centre's last inspection in July 2020. In response to these findings, the provider submitted a compliance plan response to the Chief Inspector confirming that they would address the risks through the relocation of residents identified as being at risk, and completing a review of the compatibility of all residents at the centre. However, inspectors found on this inspection that no substantive action had been taken to safeguard the residents in this centre in line with the previously submitted compliance plan, even though records reviewed showed concerns raised over the level of risk by multi-disciplinary professionals and the national safeguarding office.

Governance and management arrangements at the centre were not robust in nature and did not effectively monitor service delivery and ensure a safe service for all residents. The centre's person in charge was also responsible for the management

of the entire campus setting (four designated centres) as the Acting Director of Nursing as well as also being the person in charge for a second centre of the campus. Inspectors found this level of responsibility impacted on her ability to have both a physical presence in Dunwiley & Cloghan and also to ensure effective oversight of the centre on a day-to- day basis.

The person in charge confirmed that she had escalated identified risks at the centre to the provider, and these were also captured in completed management audits and illustrated that incompatibility issues between residents contributed to safeguarding risks in the centre. However, the provider had not implemented effective changes to address these concerns. For example; the provider audit and annual review had identified that one resident was extremely vulnerable living at the centre since January 2020, but no action had occurred to address this.

On the day of the inspection there were seven staff working in the centre during the day and four staff at night. Inspectors found that out of the five staff working in one bungalow, only one was a regular staff member at the centre, with the other four staff being redeployed due to staff sickness, absence due to injury, or not having the required positive behaviour training required for the residents' needs. This resulted in an inconsistent staff team working in the centre, who were not familiar with the residents' needs or de-escalation techniques.

Regulation 14: Persons in charge

The person in charge was appointed as person in charge of more than one designated centre and did not demonstrate effective governance, operational management and administration of the designated centres concerned.

Judgment: Not compliant

Regulation 15: Staffing

There was not a consistent staff team working in the centre. In one bungalow, only one of the five staff working were regular staff. There continued to be frequent redeployment of staff and agency staff working in the centre, due to work related injuries and staff not having the required training in positive behaviour support. This affected the continuity of care for the residents. Inspectors found no review of staff rosters had taken place to develop a centre specific staff team, as stated in the previous compliance plan.

Judgment: Not compliant

Regulation 23: Governance and management

Although significant risks were escalated to the provider frequently through various ways, such as staff reports, accident and incident reports, provider audits, annual reviews of quality and safety, multi-disciplinary and safeguarding team reports, the provider failed to take effective action to protect residents and staff in the centre. This service was institutional in practice, there was poor operational management and governance of this centre by the provider.

Judgment: Not compliant

Quality and safety

The inspector found that significant improvements were required in the quality and safety of care provided to residents in this centre. Several serious risks and safeguarding incidents had occurred which impacted negatively on residents' safety and quality of life.

Inspectors found there was a consistent pattern of serious incidents of self-harm, aggression and violence towards residents and staff in the centre, even despite additional staff supervision being put in place to protect residents. The provider had been made aware of these ongoing risks; however actions to date had not addressed them, and ensured residents' safety.

Inspectors found that there were a significant number of incidents relating to both bungalows in this centre, which included physical assaults, psychological & emotional abuse, and sexual exposure by a resident to others. These behaviours frequently resulted in displays of self-harm, violence and aggression outbursts. Behavioural supports such as increased staffing had been implemented in response to the described incidents; however these had been ineffective and in some cases had negatively impacted on other residents' freedoms within the centre. In addition, no long-term plan was in place to address this issue.

A review of residents' individual assessments and personal plans showed that they were not suitably placed in the centre. The premises and the associated environment was identified as one of the key issues that were negatively impacting on residents' behaviour, and as a result staff were constantly de-escalating incidents through the segregation of residents and the administration of PRN medication.

Furthermore, inspectors reviewed the care plans of a number of residents and found that they had not been appropriately reviewed in light of changing needs and circumstances at the centre, therefore impacting on the consistency and effectiveness of care provided to residents.

In addition, not all residents were appropriately supported to participate in a review of their care and support needs to determine if they were satisfied with the level of support or their current living arrangement in the centre. Furthermore, in one of the bungalows inspectors noted that only one resident had a formal day placement and no structured day activity programme was in place for the other residents, except for going for walks around the campus or a spin on the centre's bus.

Inspectors found that there was inconsistencies between supports as described in residents' behaviour management plans and staff practices, especially in relation to the use of restrictive practices. Due to observed inconsistencies, inspectors were not assured that agreed restrictive practices were at all times only used as a last resort or for the shortest duration necessary.

In addition, it was not clear that every effort had been made to identify and alleviate the cause of residents' behaviours of concern as described earlier in this report, especially in regards to access to food at the centre, and behaviour plans were not subject to regular review in light of the high number of incidents to ensure their effectiveness.

The provider has systems in place for the assessment, management and ongoing review of risk, which identified a high level of personal risks to both residents and staff. However, although risks were identified, implemented control measures were not proportional in nature, effective in reducing future occurrences and adversely impacted on the residents' quality of life.

Residents had been assessed as requiring communication supports to effectively express themselves, but these had not been developed or put in place by the provider. This was of specific concern in regards one resident where their multi-disciplinary assessment stated that they may become agitated when staff do not understand what they are trying to say, and this may result in behaviours of concern.

Inspectors found that the centre did not operate a rights based approach to care. Residents living together were incompatible and as a result significant risks and safeguarding concerns arose, which affected residents' choices with regard to how they spent their day and with whom they lived. Practices and facilities in the centre did not promote residents' choice and independence, with meals being prepared and delivered from an off-site kitchen which closed at 16.30 daily. Inspectors found that there was limited food choices available in the centre when the central kitchen was closed.

Overall, inspectors found that the rights of residents were not protected in this centre, as their safety, privacy and independence were not respected. Particularly in relation to, residents personal living space, communication needs and relationships with their peers. Furthermore, residents did not have the freedom to exercise choice or control in their daily lives due to the need for safeguarding measures which required staff to supervise them at all times due to the risks posed in the centre.

Regulation 10: Communication

Residents that had communication difficulties, did not have a communication profile, passport or nursing interventions in place. This is required to identify residents' specific communication need and supports and to help understand the residents needs.

Residents did not have timely access to a speech and language therapist in order to support their communication needs.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider's risks management procedures although identifying a consistently high number of incidents in the centre, did not ensure that effective risk control measures were in place to minimise the future occurrence or impact. In addition, inspectors found the provider did not effectively monitor risks in the centre, as their Quality and Safety Committee, did not meet frequently with only two meetings being convened in 2020.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' personal plans were not updated to reflect their personal goals. In addition, a resident's health issues required review due to a significant reduction in their recommended weight and awaiting a review by a dietician since January 2021. Furthermore, residents' personal goals were not person centred or aspirational in nature, being centred on the achievement of day-to-day activities only.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Staff had not received clear guidance on how to respond to incidents of self harm, aggression and violence in the centre. This lead to inconsistencies between directions in residents' crisis management and behaviour support plans and their practices. In addition, there was no evidence that alternative measures had been

considered when managing residents' behaviours of concern prior to the administering of PRN medication by staff. This was a concern to inspectors due to the high number of occasions where PRN medication had been administered to residents and it was unclear from discussions with staff and records that this was given only as a last resort.

Judgment: Not compliant

Regulation 8: Protection

There were significant safeguarding risks in this centre due to the level of incompatibility of need between residents living at the centre. Residents living in this centre were not safe and at constant risk of abuse due to their own behaviours and those of their peers. Inspectors found that there was a high number of safeguarding incidents at the centre, and although safeguarding plans were in place these were not effective in reducing future incidents and ensuring residents' safety.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider did not ensure that residents' rights were actively promoted at the centre. Residents could not walk freely around their home and feel safe, due to staff having to be aware of their peer's behaviour and the need to re-direct residents away from each other for their safety. Practices in place at the centre such as a centralised kitchen impacted on residents' choices especially as the kitchen closed at 4.30pm and limited food was available in one bungalow within the centre. Furthermore, only one residents' bungalow had a formal day service, with the other residents having no structured programme and being reliant on campus based activities and trips on the centre's bus.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Dunwiley & Cloghan OSV-0005489

Inspection ID: MON-0031963

Date of inspection: 16/03/2021

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: In order to bring this centre into compliance the following action will be taken: 1. A Person in Charge will be appointed to the centre. The recruitment process has been commenced with HR. Completion date: 10.05.2021 2. A Clinical Nurse Manager 2 will provide senior management governance and support to the centre from 23.04.2021 until the 10.05.2021 3. The governance of the centre will be further strengthened by the appointment of a Clinical Nurse Manager 1 to support the Person In Charge. The recruitment process in under way with a Clinical Nurse Manager 1 to be appointed by 10.05.2021. 4. In the interim the Clinical Nurse Manager 2 will be supported by the Director of Nursing who will have a daily meeting with the Clinical Nurse Manager 2. The Clinical Nurse Manager 2 will be further supported by the Clinical Nurse Manager 3 for Quality and Service User Safety. The Provider Representative will meet with the Clinical Nurse Manager 2 and the Person In Charge (10.05.2021) on a weekly basis to provide oversight, support and monitor the implementation of the compliance plan. Completion date: 23.04.2021	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing:	

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

1. Each centre has had an identified and dedicated staffing cohort allocated. Each Clinical Nurse Manager 2 is to complete the roster for their centre from the staff cohort. Staff from the centre's staffing cohort will be used for cover purposes. This system will be in place from the week of 26.04.2021.

2. The Director of Nursing and the Provider Representative will design a standalone roster for the centre to provide a dedicated and consistent staff team.
Completion date: 19.04.2021

3. The Director of Nursing, the Provider Representative and the Human Resource department will consult and engage with staff representative bodies regarding the implementation of the new roster. Engagement will commence by: 30.04.2021.
The roster will be implemented by 30.06.2021

4. A review of all vacancies will be undertaken in order to have posts prioritized for recruitment. The review will be completed by 30.04.2021 with a report provided to the General Manager for follow up with HR by the 14.05.2021

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 the centre into compliance the following actions will be taken:

1. A Person in Charge will be appointed to the centre. The recruitment process has been commenced with HR. Completion date: 10.05.2021

2. Compatibility Assessments have been completed.

3. On the basis of a multidisciplinary team assessment, a business case was developed and submitted by the service to the HSE National Head of Disability Operations to support the relocation of two residents from this centre to a more suitable environment. Approval was received on the 20.04.2021. A house has been identified for one resident, recruitment has commenced and transition preparations are under way as at 21.04.2021. Transition to the new accommodation for this resident will take place by 31.07.2021. A private provider is being engaged to provide a service to the second resident from this centre. Engagement with the private provider has commenced as at 21.04.2021

4. Each centre has had an identified and dedicated staffing cohort allocated. Each Clinical Nurse Manager 2 is to complete the roster for their centre from the staff cohort. Staff

from the centre's staffing cohort will be used for cover purposes. This system will be in place from the week of 26.04.2021.

5. The Director of Nursing and the Provider Representative will design a standalone roster for the centre to provide a dedicated and consistent staff team. The proposed roster was completed on 19.04.2021

6. The Director of Nursing, the Provider Representative and the Human Resource department will consult and engage with staff representative bodies regarding the implementation of the roster. Engagement will commence by: 30.04.2021. The roster will be implemented by 30.06.2021

7. An application to vary will be submitted to the Health Information and Quality Authority to reconfigure this centre making Dunwiley a standalone designated centre. Cloghan, along with Dreenan, which is currently a single house centre, will become one designated centre. Completion date: 30.04.2021

8. There will be no new admissions to the centre with immediate effect. The Statement of Purpose has been updated as at 20.04.2021.

9. Each named nurse and key worker, in conjunction with each resident will develop and implement a meaningful daily activity schedule based on each person's preferences and choice. Staff will develop a menu of daily activities that are in line with COVID restrictions. Completion date: May 15th 2021

10. Each named nurse and key worker, in conjunction with each resident will develop and implement meaningful goals in line with residents will and preference. Completion date: 15.05.2021

11. The Quality Improvement Plan for the centre will be monitored by the Provider Representative with onsite weekly visits and submitted to the General Manager's office on a weekly basis

12. A Human Rights Committee will be established to support and provide oversight to the Service. A draft Terms of Reference will be completed by the Provider Representative for all stakeholders by 30.04.2021. The first meeting of the Human Rights Committee will take place by 30.06.2021.

Regulation 10: Communication	Not Compliant

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

1. A Speech and Language Therapy Communication assessment has been completed for

one resident in Dunwiley.

2. The Speech and Language Therapist has provided training for staff in order to implement the visual communication system. This training occurred on 26.03.2021. Further training is scheduled for 30.04.2021.

3. A private Speech and Language Therapist has been contracted on a 0.3 WTE basis to the Ard Greine Court services and will provide services as follows:
• Individual assessments of service users where this is clinically warranted. Such assessments will consist of interviews with key staff, reading of reports and medical notes, face-to-face communication assessment of clients, observational assessment of clients and the communication environment, completion of reports
- Assessing and supporting capacity and consent issues
- Feeding into decongregation planning for each service user
- Staff training and follow up support
- The provision of visual materials as needed for residents on the Autism Spectrum
- Attendance at team meetings and staff liaison
- Implementation of recommendations given for each client
- Any additional qualifying work

The service commenced the week of 12.04.2021.

4. Communication profiles are in place for all residents and where the resident requires individual Speech & Language Therapy input this will be reflected in the profile. All profiles will be updated based on staff training being delivered by the Speech & Language Therapist. This process has commenced as of 16.04.2021 with all profiles to be updated by 31.05.2021.

5. The named nurse in conjunction with the key worker and the Speech & Language Therapist reviewed a communication profile for one resident living in Cloghan. Completion date: 16.04.2021

6. The named nurse updated the residents' personal plan to reflect communication preferences and support needs of this resident. Completion date: 16.04.2021

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 the centre into compliance the following actions will be taken:

1. Compatibility Assessments have been completed.

2. On the basis of a multidisciplinary team assessment, a business case was developed

and submitted by the service to the HSE National Head of Disability Operations to support the relocation of two residents from this centre to a more suitable environment. Approval was received on the 20.04.2021. A house has been identified for one resident, recruitment has commenced and transition preparations are under way as at 21.04.2021. Transition to the new accommodation for this resident will take place by 31.07.2021. A private provider is being engaged to provide a service to the second resident from this centre. Engagement with the private provider has commenced as at 21.04.2021

3. The Quality Patient and Safety committee will meet on a monthly basis to review all incidents, assess the impact of these incidents on residents and develop action plans to reduce the occurrence and impact of incidents on residents. Dates for the year have been circulated by the Director of Nursing. The Quality and Patient Safety Lead for Social Care and the Clinical Nurse Manager 3 for Quality and Service User Safety will attend. Members of the multi-disciplinary year will also attend and revised Terms of Reference reflect their inclusion. The first meeting is scheduled for 26.04.2021.

4. Each Incident is reviewed by the Person In Charge and the Director of Nursing.

5. A Clinical Nurse Manager 3 for Quality and Service User Safety has been assigned to support the Clinical Nurse Manager 2 and Person In Charge in the centre during Quarter 2 and 3, 2021.

6. A monthly audit of incidents is completed by the Person In Charge. Following analysis of the incidents, an action plan is implemented which may include that additional controls are required. Actions arising are added to the centres quality improvement plan for implementation.

7. Results of these audits are discussed at the Quality Patient and Safety committee and additional actions agreed if required.

8. Where risks cannot be managed safely within the centre as per controls identified, a risk assessment is escalated to the Director of Nursing for attention. Should the Director of Nursing not be able to manage the risk through additional controls, it is then escalated to the Disability Service Manager for review of controls and manangement. If the level of risk cannt be managed appropriately by the Disability Service Manager it is further escalated for review by the General Manager and the Quality & Patient Safety Lead for Social Care. If the risk cannot be safely managed by the controls identified, the General Manager escalates the risk to the Head of Service for review and decision. This may include the risk being put included on the Head of Service Risk Register and further escalation to the Chief Officer. The Quality and Patient Safety Lead for Social Care, the Clinical Nurse Manager 3 for Quality and Service User Safety and the Regional Director of Nursing will assist with risk management and controls at all stages as required.

9. Repairs have been completed to the window blind in the sitting room in Cloghan. Completed: 12.04.2021

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 the centre into compliance the following actions will be taken:

1. Each named nurse and key worker, in conjunction with each resident will develop and implement a meaningful daily activity schedule based on each person's preferences and choice. Staff will develop a menu of daily activities that are in line with COVID restrictions. Completion date: 15.05.2021

2. Each named nurse and key worker, in conjunction with each resident will develop and implement meaningful goals in line with the resident's will and preference. Completion date: 15.05.2021

3. The Person In Charge in conjunction with the named nurse will review and update one resident's care plan regarding weight loss to reflect the resident's GP referral on the 02.03.2021 and his Dietitian consult on the 10.03.2021. The resident remains on prescribed oral nutritional supplements and his weight will be monitored ongoing.

4. Invitations are extended to all residents' families and advocates informing them that they are invited to attend annual reviews. This process is ongoing.

5. When representatives are unable to attend the annual review the named nurse will consult with them prior to the review to ensure that their views are represented at the review. This will be documented as part of the review. Completion date: 19.04.2021

Regulation 7: Positive behavioural support	Not Compliant

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

1. A review of residents' behavior support plans, crisis management plans and restrictive reactive strategies will be completed by the named nurses in conjunction with 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. Other multi-disciplinary team members who support the resident will also participate in the review of plans. Plans are reviewed ongoing as and when changes in behaviors or new behaviours arise and indicate that a review of the existing plans and strategies is required.

Completion date: 30.04.2021

2. Each named nurse and key worker in conjunction with each resident will develop and implement a meaningful daily activity schedule based on each person's preferences and choice. Completion date: 15.05.2021

3. The named nurse will complete an audit on the use of PRN medication on a monthly basis for identified residents. This will be reviewed each month by the Person in charge, who will ensure that the prescriber is informed of the frequency of usage. Completion date: 30.04.2021

4. Behaviour support plans are in place which provide Staff will clear guidance on how to respond to incidents of self harm, aggression and violence. The plan includes alternative measures to be implemented prior to the administering of PRN medication.

5. Refresher behavior management training will be scheduled for staff working in the centre. This has commenced and will be completed with all staff updated by 30.06.2021

6. The Quality Patient and Safety committee will meet on a monthly basis to review all incidents, assess the impact of these incidents on residents and develop action plans to reduce the occurrence and impact of incidents on residents. The first meeting is scheduled for 26.04.2021 and dates for the remainder of the year have been circulated by the Director of Nursing.

7. A Human Rights Committee will be established to support and provide oversight to the service. A draft Terms of Reference will be completed by the Provider Representative for all stakeholders. Completion date: 30.04.2021.The first meeting of the Human Rights Committee will take place by 30.06.2021.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In order to bring the centre into compliance the following actions will be taken:

1. Compatibility Assessments have been completed.
2. On the basis of a multidisciplinary team assessment, a business case was developed and submitted by the service to the HSE National Head of Disability Operations to support the relocation of two residents from this centre to a more suitable environment. Approval was received on the 20.04.2021. A house has been identified for one resident, recruitment has commenced and transition preparations are under way as at 21.04.2021. Transition to the new accommodation for this resident will take place by 31.07.2021. A private provider is being engaged to provide a service to the second resident from this centre. Engagement with the private provider has commenced as at 21.04.2021

3. A review of all current safeguarding plans will be completed in Riverside 16.04.2021. A review of all safeguarding plans in Dunwiley and Cloghan will be completed by 23.04.2021.

4. A robust overarching Safeguarding Plan will be developed and implemented for each resident. A revised process has been put in place in conjunction with the CHO1 Safeguarding & Protection Team to strengthen processes in respect of the provision of supports and recommendations within the plans. All plans submitted by the Director of Nursing will be reviewed by the Safeguarding & Protection Team. All revised plans will be completed by 30.04.2021

Regulation 9: Residents' rights	Not Compliant

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

1. The Person in charge will ensure there is a varied stock of fresh and frozen food available at all times in the centre. This will ensure that residents have access to a variety of alternative food choices. Completion date: 02.04.2021

2. 2. A Shopping list will be created each week during the weekly residents meeting. Residents will be supported by staff to go shopping for food items. A record of food orders will be maintained in the centre. Completion date: 30.04.2021

3. Residents will be supported by staff to prepare simple meals in the centre if they wish to do so to facilitate residents with an alternative meal option in line with their will and preference. A range of alternative food will be consistently available in the centre. Completion date: 19.04.2021

4. The Head of Disability Service wrote to the Estates department on the 29.03.2021 requesting a preliminary review of the design and layout of the centre kitchen, utility and dining areas and to 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. The review will be completed by the 31.05.2021.

5. The 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. Completion date: 30.06.2021

6. In the interim vacant bedrooms and / or room configuration will be reviewed in each centre to support ease of access for residents to the kitchenette and provide a space where snacks and meals can be prepared. The review will be completed by 30.04.2021 and reconfiguration completed by 14.05.2021.

7. Each named nurse and key worker in conjunction with each resident will develop and implement a meaningful daily activity schedule based on each person's preferences and choice. Completion date: 15.05.2021

8. A Human Rights Committee will be established to support and provide oversight to the service. A draft Terms of Reference will be completed by the Provider Representative for all stakeholders. Completion date: 30.04.2021. The first meeting of the Human Rights Committee will take place by 30.06.2021.

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(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	31/05/2021
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	10/05/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support,	Not Compliant	Orange	26/04/2021

	particularly in circumstances where staff are employed on a less than full-time basis.			
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	10/05/2021
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	26/04/2021
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	15/05/2021
Regulation 05(3)	The person in charge shall ensure that the	Not Compliant	Orange	15/05/2021

	designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/06/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/06/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/04/2021
Regulation 7(5)(a)	The person in charge shall	Not Compliant	Orange	30/04/2021

	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.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/04/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2021
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	15/05/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in	Not Compliant	Orange	30/06/2021

	relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			