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:	Dreenan Ard Greine Court
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	05 October 2021
Centre ID:	OSV-0005490
Fieldwork ID:	MON-0033902

About the designated centre

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

This centre consists of two houses Dreenan and the Glebe. Dreenan provides full-time residential care and support for up to six adults with an intellectual disability and the Glebe house is located off campus and currently vacant due to under renovation works. Dreenan comprises of a six bedroom bungalow and supports residents with complex medical needs. Residents have access to communal facilities at the centre which include two sitting rooms, a dining room, a kitchenette, a laundry room and bathroom facilities and private bedrooms. The centre is located within a campus setting which contains a further three designated centres operated by the provider. It is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and cafes. Residents are supported by a staff team of both nurses and care assistants. During the day, residents are supported with their assessed needs by five staff members with one nurse being on duty at all times. At night-time, residents are supported by two staff, a nurse and health care assistant, with additional support being provided by a nurse in charge who is responsible for the entire campus.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 5 October 2021	09:00hrs to 17:00hrs	Thelma O'Neill	Lead

What residents told us and what inspectors observed

Overall, the residents living in the centre were well cared for and they received the care and support required to meet their health and social support needs. Improvements were found in the governance and management of the centre and protection since the last inspection. However, other areas continued to require improvements, such as in staffing, training and staff development, governance and management, a safe and suitable premise and risk management.

On arrival at the centre, residents were accessing the bus, to go out on a social outing. The provider had sourced a wheelchair accessible bus for the centre to allow residents more opportunities to take part in social activities. The provider had also provided first aid training and emergency medication training to healthcare staff to administer emergency medication or treatment, if needed, to the residents while away from the centre. These changes to the availability of transport and skilled staff had given greater access to the community, promoted choices and given a better quality of life for the residents.

During the inspection, the inspector met all the residents and observed that they had very complex medical care needs. A team of nurses and care staff cared for the residents and there was a full-time person in charge based in the centre.

The premise was found to be welcoming, with flowers at the entrance, there were two residents relaxing in the sitting room and one resident was sitting in the hallway in their comfort chair watching staff bake a cake. They appeared to enjoy the activity and the associated interaction with the staff. The inspector observed that the resident could not access the kitchen to get more involved in the activity, due to the lack of space in the kitchenette. This was an action identified on the last inspection, however, it was not yet been addressed.

Meals were provided by a centralised kitchen on campus and brought to the centre twice a day at 12.30pm and 16.30pm. Staff told the inspector that residents' choices around food and access to alternatives had improved since the last inspection, and they now had an customer account with the local supermarket which allowed them to purchase specific foods that the residents enjoyed.

On a walk around of the centre, the inspector observed that each resident had their own bedrooms. There were two en suite and four single rooms and there was also a Jacuzzi in the main bathroom which was wheelchair accessible. There was one vacancy in the centre on the day of inspection, with the vacant room being used at the time as an additional staff room in line with the centre's COVID-19 contingency arrangements.

The residents' bedrooms were nicely decorated and individualised to reflect their preferences and assessed needs. Residents' bedrooms had personal photographs and ornaments on display for them to enjoy. The residents appeared both relaxed

and comfortable in the house.The inspector observed that a ceiling hoist had been installed since the last inspection in one resident's bedroom and staff told the inspector that this equipment had improved the resident's quality of life, as it meant less transfers and greater safety when mobilising the resident from their chair to bed.

Since the COVID-19 pandemic, the views of families had been were sought through alternative communications rather than face-to-face meetings, such as phone calls, questionnaires or the use of technology. Residents' goals had been reviewed and where goals could not be met due to the public health restrictions, new goals had been identified and were being worked on. These included baking, skills-building in identified areas, exercise plans and gardening projects.The centre had a secure garden that was wheelchair accessible and there was patio furniture for residents to sit and relax on outside and enjoy the garden. Prior to the COVID-19 public health restrictions, one resident attended a nearby day service while others carried out day activities from their home.

Residents also had timely access to health care professionals and the inspector saw evidence that residents' health care needs were being met by appropriate health care professionals.

The inspector met with the six staff on duty on the day of inspection. They were familiar with residents and were generally based in the centre. A reviewe of the staff rosters in the centre confirmed this, but the records showed that staffing consistency was an issue in the centre with frequent staff changes between Dreenan and other centres on the campus.

Through reviews of documentation, observations and speaking with staff, it was clear that the person in charge and staff team were very supportive to the residents and responsible for ensuring that the care and support provided was person-centred in nature and effective in meeting their needs. However, many of the governance issues that were identified on previous inspections were not fully addressed. However, the provider had implemented a quality improvement plan to address these issues, and they will be discussed later in the report.

Capacity and capability

The provider had improved its governance and management of the centre since the last inspection in order to ensure effective oversight of the service. However, some actions from previous inspections were still not addressed and continue to be work in progress. These included the commencement of recruited Clinical Nurse manager (CNM1) posts to strengeth the day-to-day management of the centre, improved staffing arrangements and training.

A new acting Director of Services for the campus had been appointed to the centre in August and the person in charge (PIC) was based in the centre to manage the

day-to-day operations of the centre. The PIC was full-time in the centre and was a registered nurse for people with disabilities and mental health. The provider had also appointed a new Clinical Nurse Manager 1 (CNM1) to the centre, who was already working in the centre as a staff nurse, however, they had not commenced their new role on the day of inspection, due to the shortage of nurses in the centre. The person in charge told the inspector that although not fully commenced, the CNM1 role had already helped to strengthen the overall governance and management of the centre and they were looking forward to it being fully implemented in coming weeks.

Since the last inspection, the provider had implemented a number of improvements across the campus, which were part of the Ard Greine Court Management Improvement Plan and in response to the findings of the campus previous inspections. Although some of these actions were not fully completed, the inspector saw evidence of improvements in the centre.

The person in charge completed internal audits including health & safety audits, staffing and accidents & incidents and there was good oversight of the quality and safety of care in the centre. Residents care notes were well maintained and clearly identified residents' complex medical issues and nursing interventions.

In addition, the monitoring of the care and support provided was further reinforced through the provider's quality assurance audits as described in the regulations. The provider undertook six monthly unannounced visits of the centre as well as an annual review into the care and support provided.

As stated earlier, appropriate numbers of suitably qualified staff were engaged at the centre to meet residents' needs. However, the consistency of the staff team was not being maintained as there was evidence that staff nurses in particular, were regularly required to work in other parts of the campus, which impacted on planned isocial activities for residents.In addition, one resident required one-to-one staffing and sue to shortages this was reliant on an agency staff member.

Staff knowledge of the residents' care and support needs was reinforced through them having regular access to training, with reviewed records showing that all staff having completed outstanding training since the last inspection. However, staff training records did not include all staff working in the centre and this required review. Furthermore, outstanding training relating to supporting residents with their sexuality was scheduled, but was not due to commenced until after the inspection.to take place in the coming weeks.

Regulation 15: Staffing

There were sufficient staff working in the centre; however agency staff were used on a daily basis and there continued to be frequent redeployment of staff to other designated centres which affected the continuity of care for the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a schedule of training for all staff working in the centre; however some staff training was outstanding such as positive behaviour support. In addition, the training records for all staff working in the centre were not included in the staff training matrix.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had strengthened the governance and management of the centre since the last inspection. However, the CNM1 could not yet take up their post due to the shortages of nurses in the centre.

In addition, the actions from the last inspection in relation to premises, staffing and protection had not been completed; although plans were in place by the provider to address these actions in the campus' quality improvement plan.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents received a good quality and safe service in this centre. There were suitable arrangements in place to manage the centre and meet residents' health and social care needs.

There were assessments of needs completed for each resident which assessed their health, personal and social care needs. Plans were developed to support residents and guide staff in their care need requirements. In addition, each resident had a personal plan which included information about their communication preferences, likes, dislikes, daily routines and what goals they would like to achieve over the year. Residents' individual assessments were found to be comprehensive in nature and nursing interventions were well documented and kept up-to-date.

Since the last inspection, multidisciplinary supports had increased in the centre and across the campus. Speech and language therapists, and a clinical nurse specialist in behaviour were appointed to posts at the campus. This was to support residents'

care and support needs. There were some waiting lists in place to access these, and other multidisciplinary services; however, overall residents' healthcare needs were well met in the centre.

Residents that displayed behaviours of concern had behaviour support plans in place, and these were up-to-date and regularly reviewed. However, some staff required training in positive behaviour support. The inspector found that the management team had identified that one resident that was not suitably placed at the centre, as the service was not suitable for their care and support needs. As a result, they have been placed on a list to move to another centre. There were also restrictive practices in place in the centre, and these practices were under regular review.

Each resident had an overarching safeguarding plan in place, which identified individual protection risks posed to them in the centre. There were control measures in place to prevent such risks occurring in the future. In addition, since the last inspection, the provider had also provided an occupational therapy assessment for two residents as part of a historical safeguarding review and training for all managers and staff were scheduled to take place in October 2021.

Since the last inspection, the provider had taken measures to improve the institutional practices in this centre, which had impacted on the residents' quality of life. For example, residents had access to independent advocacy services and restrictions around food choices, and access to the community had been resolved.

Although the centre was clean and welcoming, the design and layout of the premise was not accessible for residents who were wheelchair users. There was also a lack of storage space in the centre to store wheelchairs and equipment. The inspector saw equipment continued to be stored in communal areas. However the provider had submitted an improvement plan for the campus to address these issues, but the action was still in progress and not completed. Issues around the accessibility and storage issues in the centre remains an issue and is actioned under the regulation safe and suitable premise.

The provider had identified and managed each risk in the centre. However, they had not identified all the risks on the centre risk register. For example, a number of residents had a history of falls, and were receiving constant staff supervision, but this risk was not risk rated and included on the register.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. Staff had undertaken online training courses in infection prevention and control; including hand hygiene and the correct use of PPE. The person in charge had completed a self-assessment audit to assess the centre’s preparedness for a COVID-19 outbreak and contingency plans were in place to include staffing shortages and isolation of residents if required.

Regulation 17: Premises

The design and layout of the premise was not fully accessible for residents who were wheelchair users. There was also a lack of storage space in the centre to store wheelchairs and equipment. However, the provider had submitted an improvement plan for the campus to address these issues, but the action was still in progress and not complete.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had identified and managed individual risks in the centre. However, they had not identified all of the risks such as a number of residents who had a history of having falls and were receiving constant staff supervision. These risks were not risk rated or included in the organisational risk register.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The management of Infection prevention and control practices at the centre were comprehensive in nature and had been enhanced in light of the provider's COVID-19 policies and the implementation of public health restrictions. Staff had received COVID-19 related training and had easy access to both PPE and alcohol sanitizer supplies at the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents individual assessments were found to be comprehensive and nursing interventions were well documented and kept up-to-date. Residents' personal plans for social activities were also in place and there was clear evidence of person centred planning (PCP) meetings with the residents and actions plans with timely goals set to achieve over the summer.

Judgment: Compliant

Regulation 6: Health care

Multi-disciplinary supports had increased in the centre and across the campus since since the last inspection. There was some waiting lists in place; however, overall residents healthcare needs were being met.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents that displayed behaviours of concern had behaviour support plans in place that were up-to-date and regularly reviewed. There were also restrictive practices in place in the centre and these practices were under ongoing review.

Judgment: Compliant

Regulation 8: Protection

Each resident had an overarching safeguarding plan in place, which identified the individual risks posed, and the control measures in place to prevent such risks occurring in the future. The provider had also provided residents with access to an occupational assessment, as part of a safeguarding review and training for all managers and staff was scheduled to take place in October this year.

Judgment: Compliant

Regulation 9: Residents' rights

Since the last inspection, the provider had taken measures to improve the institutional practices in this centre, which had previously impacted on the residents quality of life. For example; restrictions around food choices and access to the community. Issues around the accessibility is actioned under premise.

Judgment: 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dreenan Ard Greine Court OSV-0005490

Inspection ID: MON-0033902

Date of inspection: 05/10/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The Person in Charge has assigned a consistent cohort of staff for the centre supplemented by a regular number of agency staff assigned for the centre to ensure continuity of care for all residents. Completion date: 26/10/21 2. The Person in Charge and Director of Nursing will establish a roster to ensure that the centre will be stand alone. Completion date: 31/12/21 3. The provider will ensure that the CNMI appointed to the centre will be in a position to fully discharge the role. Completion date: 01/11/21	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. A full review of training requirements for the centre has been undertaken. Completion date: 07/10/21 2. The Person in Charge has schedule all outstanding training Completion date: 07/11/21 3. The PIC will ensure that training in the sexuality in supported settings for adults who have an intellectual disability will be delivered to all staff. Completion date: 31/12/21 4. The Person in Charge will monitor scheduled training and the training matrix on a monthly basis. Completion date: 30/11/21	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The provider will ensure the CNMI appointed to the centre will be in a position to fully discharge the role. Completion date: 01/11/21 2. The Person in Charge has assigned a consistent cohort of staff for the centre supplemented by a regular number of agency staff assigned for the centre to ensure continuity of care for all residents. Completion date: 26/10/21 3. The PIC will ensure that training in the sexuality in supported settings for adults who have an intellectual disability will be delivered to all staff. Completion date: 31/12/21 4. The Director of Nursing and Provider Representative are in discussion with the housing association in relation to reconfiguring the layout of the centre. Initial discussions commenced on 23/09/21 and plans have been shared. Further engagement planned to complete the reconfiguration. Completion date: 31/03/22	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. The Director of Nursing and Provider Representative are in discussion with the housing association in relation to reconfiguring the layout of the centre. Initial discussions commenced on 23/09/21 and plans have been shared. Further engagement planned to complete the reconfiguration. Completion date: 31/03/22 2. The PIC has undertaken a full review of storage within the centre and taken action to ensure equipment is stored in appropriate spaces. Completion date: 15/11/21	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 1. The Person in Charge in liaison with the CNM3 Quality Risk & Service User Safety has commenced a review of the Risk register to ensure it accurately reflects all risks within the centre. Completion date: 30/11/21	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/12/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and	Substantially Compliant	Yellow	31/03/2022

	objectives of the service and the number and needs of residents.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2022
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.	Substantially Compliant	Yellow	30/11/2021