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:	Dunroamin
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	14 March 2022
Centre ID:	OSV-0008117
Fieldwork ID:	MON-0034686

About the designated centre

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

Dunroamin provides 24 hour residential care to meet the care needs of 4 adult residents with moderate to severe intellectual disability who require support with their social, medical and mental health needs. The centre consists of a large bungalow in a rural setting. All residents have their own bedrooms, while 2 residents also have en-suite facilities, with level access shower facilities available. A living room is available for entertainment, relaxation and socialising. Dunroamin has a sun room for private visits and activities whilst enjoying the good weather. There is a kitchen/dining area where residents can prepare and enjoy meals and snacks, the houses has laundry facilities. Office space is located in the centre. Residents can also enjoy the garden and outdoor sitting area. The residents of the Centre are supported by a defined compliment of nursing and care staff under the supervision and support of the CNM2/PIC and CNM1. A 24 hour on-call nursing service is also provided. The staff team assist the residents to live and integrate as fully as possible into their local communities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 14 March 2022	12:15hrs to 16:30hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

In this centre there was evidence of good quality care and a person-centred service. Residents appeared to have a good quality of life and they were supported to engage in activities that were meaningful to them.

The centre was a bungalow in a rural location. The residents had moved to the centre in recent months and this was the first inspection of this centre. The house was newly renovated and refurbished to a high standard and to meet the needs of the residents. The house was warm, comfortable and tastefully decorated. It was clean and tidy. Each resident had their own bedroom and each were decorated in individual styles in line with the residents' taste. Every room had its own television. Two rooms were en-suite and there was a shared bathroom for the other two residents. Each bedroom was fitted with a tracking hoist. Residents had profiling beds where needed. The communal rooms in the house were bright, spacious and had new, comfortable furniture. The house was fully accessible with level entry at the front and back doors. Outside, the grounds were well maintained. There was a pleasant atmosphere in the house. It was noted that televisions and radios were tuned to stations that were chosen by the residents.

The inspector met with all residents on the day of inspection. Two residents were happy to talk to the inspector about their home. They reported that they liked their new home and new bedrooms. One resident said that they lived in a 'beautiful house' and that they were happy in their home. They talked about some of the tasks that they complete in the house and their hobbies. They talked about the food in the centre and said that they were happy with the food and cooking. One resident showed the inspector a craft project that they were completing. Residents left the centre at different times during the day to attend appointments and activities. The centre had its own bus to facilitate these outings.

Staff interacted with residents in a friendly and respectful manner. They were knowledgeable of the residents' preferred topics of conversation. Staff were heard chatting and singing with residents throughout the inspection. It was noted that residents were offered choices throughout the day in relation to food and activities. There was flexibility throughout the day to suit the needs of residents. For example, it was noted that one resident was taking a nap when lunch was being prepared. The resident was not disturbed and staff were able to prepare lunch for that resident at a later time.

Overall, there was evidence of a good service in this centre. There was a homely feel and pleasant atmosphere in the house. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

There was good oversight in this centre that ensured that residents received a good quality service that was in line with their assessed needs. However, improvement was required in relation to staffing, staff training and the residents' written agreements.

The inspection was facilitated by the person in charge who had very good oversight of the service. The person in charge knew what was required to address the individual needs of each resident and the service as a whole. There were clear lines of management and accountability within the service. There were clear reporting relationships within the centre. As the centre was open less than six-months, the provider had not yet completed an annual review or an unannounced audit of the safety and quality of care and support in the centre. However, there was a schedule of planned audits of different areas of service delivery. These audits were scheduled to be completed at different points in the year and records showed that these audits had been completed in line with this schedule. The person in charge reported that issues identified on audit were addressed immediately, where possible. Where it was not possible to address issues immediately, they were escalated to senior management and added to the centre's quality improvement plan. A review of this plan noted that service improvements had been identified by the person in charge and that time-specific action plans were in place. There was evidence that actions were being progressed and completed. The quality improvement plan was reviewed and updated monthly. A review of minutes showed that audit findings and service improvement plans were discussed at team meetings in the centre and at local management team meetings. Team meetings in the centre were held monthly and at different times in the day to capture day staff and night staff. In addition, there was a communication diary in the centre where day-to-day issues and resident appointments could be recorded and shared between staff.

Planned and actual staff rosters for the centre were reviewed and, for the most part, staffing arrangements were in line with the residents' needs. However, it was noted that there had been a number of incidents in recent weeks where the staffing numbers and skill mix were not in line with the provider's own staffing guidelines for the centre. This was due to unplanned leave. The rosters indicated that there were only two staff on duty on a number of dates in March 2022. However, the person in charge reported that they had worked on those days to fill the staffing shortage. This had not been recorded on the staff roster. In addition, the person in charge reported that a nurse should be on-duty at all times in the centre and it was noted that this had not been the case on 08/03/22 where no nurse was available for night duty. The person in charge reported that the staff on duty that night were suitably trained in the administration of medication and that on-call nursing support was available, if required.

A review of the training matrix for the centre found that staff training was largely up to date in the provider's mandatory modules. The person in charge kept certificates of individual staff training and presented these records to the inspector. The person

in charge had identified staff members who required refresher training in certain modules. In some cases, planned dates for this training had been identified. For example, six staff needed refresher training in managing behaviour that is challenging and a session had been booked in the coming weeks. However, one member of staff had no training in this area and there were no dates booked for this staff member to complete this module.

The inspector reviewed the complaints procedure in the centre. There were no open complaints in the centre at the time. The complaints procedure was on display in the centre in an easy-to-read format. Contact details of the complaints officer were on display. Complaints in the centre were audited regularly throughout the year.

The written agreements for the residents were reviewed. Each resident had a written agreement with the provider from their previous centre. However, there were no written agreements in place for the residents since they moved to their new centre. Therefore, there was no agreement between the provider and resident that outlined the terms of residency in the new centre, the services that would be provided, or the fees that would be charged to the resident.

Overall, there was good oversight in this centre and issues identified were addressed. However, some improvement was required in relation to staffing and the recording of rosters, staff training and there were no written agreements in place for the residents.

Regulation 15: Staffing

Overall, the staffing number and skill-mix in the centre was adequate to meet the assessed needs of residents. Where recent staffing shortages had occurred, the person in charge had ensured that staff on-duty had the relevant skills to meet the residents' needs. However, it was noted that the staff rosters did not accurately reflect the staffing arrangements in the centre at all times.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff training was largely up to date in areas that the provider deemed mandatory. However, in some cases where staff training was required, dates for this training had not been identified.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was good oversight and management in the centre. Audits were routinely completed and findings from these audits were escalated and addressed, as required. There were clear lines of management and reporting relationships in the centre.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

A written agreement between the resident and provider had not been put in place in the centre to outline the terms of residency for the residents.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a complaints procedure in place. This was displayed in the centre in easy-to-read format. The contact details of the complaints officer were displayed. Complaints in the centre were routinely audited.

Judgment: Compliant

Quality and safety

Residents' wellbeing and welfare was maintained by a good standard of care and support. Residents were supported to take part in activities that were meaningful to them and in line with their interests.

The centre itself was very comfortable and homely. It was suited to the needs of residents and equipped to support residents should there be a change to their care needs in the future. There was adequate room for residents to spend time together or in private. The centre was clean and tidy. The provider had checklists in place to record the cleaning completed in the centre. A review of these checklists showed that tasks were completed in line with the checklists. However, signatures and initials on checklists were not recorded in line with the provider's guidelines. In addition to the routine cleaning, enhanced cleaning schedules were in place to

combat the risk of infection from COVID-19. Staff also completed symptom checks at the beginning of each shift and temperature checks throughout the shift. It was noted, however, that five staff required training in relation to infection prevention and control. The provider had devised plans to support residents isolate in their own rooms in cases of suspected of confirmed COVID-19. Support was available from a local infection prevention and control team. Staffing contingency plans in the event of an outbreak of COVID-19 were in place and issues could be escalated to senior management as needed.

Residents' safety was promoted in this centre. Staff were trained in safeguarding. Incidents were recorded and escalated in line with the provider's policy. Incidents were reviewed at monthly incident review meetings with local management. Staff were knowledgeable on the appropriate measures to take if there was any concern in relation to abuse. On the day of inspection, there were no open safeguarding concerns in the centre.

The provider had measures in place to protect residents in case of fire. Fire doors were fitted throughout the centre and were fitted with magnetic door closers. Regular fire drills were completed under different simulated conditions and learning from these drills were recorded. The provider had employed an external fire company to complete routine checks and maintenance of emergency lighting and equipment for the detection and extinguishing of fires. Staff completed checks of fire equipment weekly and it was noted that staff had detected a faulty break-glass unit. This had been reported to an external fire company for repair. Risk assessments and personal evacuation plans for residents were available for review and these gave clear guidance to staff on actions that should be taken in the event of a fire.

In addition to the fire risk assessments, the person in charge kept a comprehensive risk register in the centre that identified a number of risks in the service and the relevant control measures needed to reduce these risks. These assessments were regularly reviewed and updated, and new risks added as they arose. In addition, residents had individual risk assessments that were kept up to date and gave clear guidance to staff on how to reduce risks to residents.

The individual risk assessments formed part of the residents' support plans. An assessment of residents' needs had been completed in line with the regulations. Corresponding support plans were devised from this assessment. These plans outlined how best to support the resident to meet their health and personal needs and goals. In addition, a detailed medical history of each resident was maintained. There was evidence of input from a wide range of health professionals as required by each resident. The plans were regularly reviewed and updated. This included positive behaviour support plans. These plans were devised with input from a behavioural specialist and psychiatry. The plans were updated and reviewed and staff were knowledgeable on the content of the plans. Any restrictive practices that were used in the centre had been referred to a restrictive practice committee and reviewed annually to ensure that they were the least restrictive practice possible. The residents' personal and social goals were outlined in a personal plan that was kept in the residents' room and contained photographs of activities that had been

completed by residents.

As outlined above, staff interacted and communicated with residents in a caring manner. Staff were knowledgeable on the communication needs of residents. The residents' support plans contained communication passports and profiles that gave clear guidance on the communication needs of residents and how best to support them with their communication. The plans were routinely updated. Residents had access to speech and language therapy, as required.

A review of daily notes showed that residents were supported to engage in a wide range of activities that were of interest to them. This included activities in the centre and activities in the wider community. For example, residents were supported to attend fitness classes, visit friends, go out for a meal, complete crafts, and go shopping. Residents were supported to re-engage with day services as they reopened following the easing of COVID-19 restrictions. Individualised arrangements were in place to ensure that residents could participate in on-line classes and also attend some sessions in person.

Overall, residents in this centre received a good quality and safe service. Supports were available to meet their assessed needs and residents were enabled to fulfil their personal and social goals.

Regulation 10: Communication

Residents' communication needs were identified and plans clearly outlined the communication supports required by residents. Staff were knowledgeable on the residents' communication needs. Residents had access to television and internet.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to engage in activities in accordance with their interests and needs. Residents were suported to mainatin links with family, friends and the wider community.

Judgment: Compliant

Regulation 17: Premises

The centre was designed and laid out so that it met the needs of residents. There

was adequate communal and private space for residents. Assistive aids and appliances were available for residents' use. The centre was in very good structural and decorative repair. The centre was fully accessible to all residents.

Judgment: Compliant

Regulation 26: Risk management procedures

A comprehensive risk register was maintained in the centre. Residents had individual risk assessments. Risk assessments were routinely reviewed and updated. There were clear means of escalation if any adverse incidents occurred.

Judgment: Compliant

Regulation 27: Protection against infection

The centre was clean and tidy. The provider had taken measures to ensure that residents were protected from infection. There were plans in place to support residents in cases of suspected or confirmed COVID-19 . Cleaning tasks and routine cleaning tasks were completed in line with the provider's guidelines. However, documentation in relation to cleaning checklists and staff training in infection prevention and control required improvement.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had taken measures to ensure the safety of residents in relation to fire. Fire drills were completed routinely and learning was recorded. Residents had personal evacuation plans that clearly guided staff on what to do in the event of a fire. The provider had made arrangements for the maintenance of equipment relating to fire detection and emergency lighting. The provider had checklists and audits to check the centre routinely in relation to fire safety.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' health, social and personal needs were assessed. Goals and plans were devised to meet these needs. The plans were routinely reviewed and updated.

Judgment: Compliant

Regulation 6: Health care

The health needs of the residents was well managed. Health assessments were conducted. Care plans were devised for any health need identified on the assessment. There was evidence of input from a variety of health professionals as required by residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans were devised with input from a behaviour support therapist. Staff were knowledgeable on the content of these plans. Any restrictive practices were regularly reviewed by a restrictive practice committee.

Judgment: Compliant

Regulation 8: Protection

The provider had measures in place to protect residents from abuse. All staff were trained in safeguarding. Safeguarding was included in the provider's audit schedule. Staff were knowledgeable on the steps that should be taken in cases of suspected abuse. The residents' personal plans included intimate care plans.

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 (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	Compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dunroamin OSV-0008117

Inspection ID: MON-0034686

Date of inspection: 14/03/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The person in charge has ensured that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The person in charge has ensured that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme • Three staff have completed Studio three training on the 7th April 2022. A Schedule is now in place as agreed with trainers for remaining staff to complete their refresher training up to the 6/6/2022. • Six staff requires CPR training, a schedule is now in place to complete this training by the 6/6/2022. • Five staff have completed their fire training on the 8th April 2022, with the remainder staff scheduled for training up to 31/5/2022. • Three staff require manual handling. A training plan is now in place for staff to complete this training up to 6/6/2022.	

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• The Register Provider has ensured new contracts of care is completed reflecting the new Designated Center where the resident reside.

• The Person in Charge has ensured all financial requirements and payments are clearly identified to the Residents in their Contracts of Care.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The registered provider has ensured that the standards for the prevention and control of healthcare associated infections is maintained within the Designated Centre.

The Person in Charge has ensured new environmental records are now in place, which contain more detail to ensure the safety of Residents in the Designated Centre.

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	04/04/2022
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	30/06/2022
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which	Not Compliant	Orange	30/04/2022

	that resident shall reside in the designated centre.			
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 associated infections published by the Authority.	Substantially Compliant	Yellow	04/04/2022