Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	James Connolly Memorial Residential Unit
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	06 June 2019
Centre ID:	OSV-0002502
Fieldwork ID:	MON-0023789

About the designated centre

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

James Connolly Memorial Residential Unit is a congregated setting proving care and support to16 adults with disabilities (both male and female) in Co. Donegal. The premises consist of a large two storey building and are institutional in design. Communal facilities include two large sleeping dormitories (where five female residents sleep in one dormitory and four male residents sleep in the other). There are also three single and two double occupancy bedrooms. All bedroom facilities are on the ground floor of the centre. The ground floor also comprises a large bright sitting/TV room, multiple bathroom/restroom facilities, a relaxation/sensory area, dining rooms and a small kitchenette which is available for residents to use. There is also a larger industrial-style kitchen on the ground floor (not accessible to the residents) that provides meals at specific times throughout the day to residents. The second floor of the building comprises of facilities for management and staff of the centre to include offices, a kitchen, a dining area and staff restroom. The centre is located on a site from which a range of other Health Service Executive (HSE) services are accommodated. The building is surrounded by gardens and grounds that are well maintained and private parking facilities are also available. The centre is staffed on a 24/7 basis with a full time person in charge (who is a clinical nurse manager II), a team of staff nurses and a team of health care assistants. Access to GP services and other allied healthcare professionals form part of the service provided to the residents. Transport is also provided for residents to have access to nearby towns and go on drives to the local countryside and nearby beaches.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
06 June 2019	08:30hrs to 16:30hrs	Raymond Lynch	Lead
06 June 2019	08:30hrs to 16:30hrs	Gary Kiernan	Support

Views of people who use the service

The inspectors met and spent time with six of the residents who use this service. Residents communicated by use of body language, facial expression and sound and were supported by staff at all times throughout the inspection.

The inspectors observed that the centre was institutional in design and was not an appropriate environment for people with disabilities to live in. Residents' right to privacy and dignity was compromised as a result of this. There were multiple occupancy bedrooms in use with five residents having to sleep in one dormitory and four in the other. While the inspectors saw that staff were using curtains and mobile screens during personal care, these arrangements did not support residents' right to privacy and a homely environment. The inspectors noted a resident sleeping on one dormitory while a number of staff including cleaning staff proceeded with their duties in close proximity.

Due to the layout of the building, mobile medical screens had to be used in communal areas, such as corridors, when residents wanted to access bathrooms and showering facilities. The centre also comprised of an industrialised kitchen which residents were not permitted to access and their dining room was being used on a daily basis to provide meals to people from a nearby day service who did not live in the centre. Residents did not have access to the first floor of the centre which was assigned for staff and office use.

The inspectors also noted that residents liked to use their community however, opportunities for social outings were very limited due to the staffing arrangements in place. A number of residents did not leave the centre or its environs on the day of inspection. A review of a number of personal plans documented that residents liked to avail of social outings and trips such as going on holidays, to restaurants, for a drink and to the shops. However, records of residents daily activities showed that community-based outings were significantly restricted. One resident who particularly liked swimming had not been supported to go on swimming in the last two years, even though a public swimming pool was available to use in Derry city and within driving distance from the centre. Residents also liked to avail of overnight stays in hotels and go on holidays; however, activities such as these were not being adequately provided for. It was also observed that residents were referred to as 'in patients' on the template of their personal plans.

Notwithstanding these issues, residents were observed to be relaxed and comfortable in the presence of staff members and staff were seen to be attentive to their needs. The inspectors sat with some of the residents and staff members in the sitting room and observed that staff understood and were respectful of the communication style of each resident. Residents were seen to smile when staff interacted with them and the inspectors saw that they enjoyed sensory activities and relaxation therapies such as foot and facial massage. Staff were also observed

to spend meaningful quiet time on a one-to-one basis with some of the residents, discussing topics of interest such as music and concerts while providing hand messages. The inspectors observed that residents appeared reassured and very contented with such interaction and they regularly smiled and held the carers' hands during this activity.

Staff members were observed to direct and support the residents in their interactions with other residents in order to keep them safe.

Capacity and capability

This centre was not adequately resourced or managed to ensure the effective delivery of care and support to the residents. It was institutional in design and did not provide for an appropriate living environment for people with disabilities.

The governance and management arrangements were not effective in addressing substantive issues such as providing appropriate accommodation for all residents in a timely manner. The provider had previously submitted plans to the chief inspector to provide appropriate accommodation, however these plans were not adhered to and it was evident that a number of deadlines had been missed. It was not demonstrated that the governance arrangements had responded appropriately to this situation. Issues of non-compliance were also identified pertaining to residents' rights, their general welfare and development, risk management, assessed social care needs, positive behavioural support and protection which are discussed in greater detail in the Quality and safety section of this report. Due to the nature of some of these non-compliances and the impact which they had on the residents, the chief inspector decided to prescribe the time frame by which the provider is to come into compliance.

The centre had a management structure in place consisting of an experienced person in charge (clinical nurse manager II) who worked on a full-time basis with the organisation and was supported in her role by a team of staff nurses and healthcare assistants.

However, the provider's arrangements to provide a staff team to meet the assessed needs of the residents was not effective. The skill-mix of the staff team required review as the assessed social care needs of the residents were not being adequately provided for under the current arrangements. In accordance with arrangements which had been put in place by the provider, residents with epilepsy required the support of qualified nursing staff at all times to leave the centre or go on social outings. Because there were only two qualified nurses on duty throughout the day (who were also required to cover medication rounds and provide clinical care), community access and social outings were very limited for a number of these residents due to the arrangements in place. As a result there were direct negative impacts on the residents and their quality of life. A review of residents daily activity logs and daily expense logs showed that some residents were not accessing

community-based facilities for prolonged periods of time. Where this was the case, residents were being offered walks around the campus and activities within the confines of the building.

A risk assessment completed in early 2019 also identified that as part of the staff skill-mix two behavioural support specialists were required as additional control measures to support residents with managing significant and complex behaviours of concern. These specialists had not been secured by the time of this inspection and there were no immediate plans in place to address this issue. This is further discussed under regulation 26: risk management.

Notwithstanding these challenges, of the staff spoken with and observed over the course of this inspection, the inspectors were assured that they had the skills, experience and knowledge to support the residents in a caring, professional and consistent manner. Staff interaction with residents was seen to be warm at all times, and over the course of this inspection staff were seen to be attentive to the needs of the residents. However, some gaps were noted in staff training including the management of challenging behaviour. This was of concern to the inspectors as a high number of residents presented with behaviours of concern in the centre, there were some peer-to-peer related safeguarding issues and some residents had issues with self-injurious behaviours resulting in injury and bruising.

The centre was monitored and audited as required by the regulations. There was an annual review of the quality and safety of care available along with six-monthly auditing reports. However, these reviews and audits did not substantially address the critical issues related to the decongregation of the centre or adequately address the unsuitability of the premises in providing an appropriate individualised service to people with disabilities. It was also observed that the auditing process did not identify that the designated centre was inadequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. For example, the issue of residents having limited access to their community due to the staff skill-mix had not been identified.

Prior to carrying out this inspection, the provider had submitted notifications to the Chief Inspector, detailing a high number of incidents of bruising and various injuries to residents. In response, the provider was required to return an assurance report to HIQA addressing how this issue was being managed to keep residents safe. The provider responded and submitted to a report to HIQA based on a detailed review which they had carried out; however, it was of concern that this review had not taken place prior to the request made by HIQA. While the review provided some useful assurances and demonstrated the reasons for a number of the incidents experienced by individual residents, it did not address the overall issue in a comprehensive way at the centre and organisational level. During the inspection it was seen that staff in the centre documented all accidents and incidents and there were regular reviews and audits by the person in charge. However, residents continued to sustain bruising and injuries and it was evident that further review and action was required at the organisational level to address this. Therefore, it was not demonstrated that the provider was gathering and using information well in order to

drive safe, quality care for residents.

Overall, from spending time with the residents and staff over the course of this inspection the inspectors were assured that staff supported the residents in a caring and professional manner and were knowledgeable of their assessed needs. However, the systems of government and management were not effective in ensuring the service provided to the residents was appropriate in meeting their assessed needs. These systems were also not effective in identifying and addressing issues of non-compliance and issues which adversely impacted on the residents' quality of life.

Regulation 14: Persons in charge

The inspectors found that there was a person in charge in the centre, who was a qualified professional (Clinical Nurse Manager) with significant experience of working in and managing services for people with disabilities.

She was also aware of her remit under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Judgment: Compliant

Regulation 15: Staffing

The staffing skill-mix in place to meet the assessed needs of residents required review to ensure residents had access to their community and could engage in social activities of interest.

Judgment: Not compliant

Regulation 16: Training and staff development

Some gaps were identified in staff training, including training in the management of

behaviours of concern.

Judgment: Substantially compliant

Regulation 23: Governance and management

The oversight arrangements of the centre required review as the auditing processes and annual review of the quality and safety of care did not substantially address the critical issues related to the unsuitability of the premises to provide an appropriate individualised service to people with disabilities.

Information was not being gathered and used well to maintain adequate oversight and drive improvement in the service. Residents continued to sustain bruising and injuries and it was evident that further review and action was required at the organisational level to address this area.

Judgment: Not compliant

Regulation 3: Statement of purpose

The service was not being delivered in line with the statement of purpose. Access to ordinary community places (as identified in the Statement of Purpose) was limited for many of the residents living in the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge was aware of their remit to notify the Chief Inspector of any adverse incident occurring in the centre as required by the regulations.

Judgment: Compliant

Quality and safety

The quality and safety of care provided to the residents required review and improvement. While residents' healthcare and medical needs were being comprehensively provided for, they were not being supported to have meaningful and active lives in their community, the premises were institutional in design (and this was impacting negatively on residents' rights to privacy and dignity) and the process of managing risk required review.

The individual social care needs of residents were not being supported and residents' access to community-based facilities for recreational purposes was limited. While it was observed that residents like to engage in social activities such as going to mass, swimming, overnight hotel breaks, going to restaurants, shops, pubs and drives in the countryside, the provider was not putting effective arrangements in place to meet the assessed social needs of each resident and residents had limited opportunities to participate in social activities of interest. From reviewing a number of residents daily activity logs the inspectors observed that residents could go for prolonged periods of time without leaving the grounds of the centre. In turn, aspects of the residents' individual personal plans were ineffective and not being adequately reviewed.

Residents' healthcare needs were being comprehensively provided for and, as required, access to a range of allied healthcare professionals formed part of the service provided. The inspectors saw that residents had access to GP services, dentist, optician and physiotherapy. Hospital appointments were facilitated as required and comprehensive care plans were in place to support residents in achieving the best possible health. These plans helped to ensure that staff provided consistent care in line with the recommendations and advice of the healthcare professionals.

Residents were also supported to experience best possible mental health and, where required, had access to psychiatry support. Where required, residents had positive behavioural support plans in place and most staff had training in positive behavioural support techniques so they had the skills required to support residents in a professional, calm and competent manner if required. However, there were some gaps identified in staff training for positive behavioural support. A risk assessment also identified that in order to better support residents with their behaviour, additional therapeutic support and intervention was required to include additional psychology input, as well as additional support from two behavioural specialists. These supports were not in place at the time of this inspection.

There were a number of restrictive practices in place. It was observed that PRN medication (as required) was used to support some residents with behaviours of concern. However, the recording practices around the administration of this PRN medication required review. For example, staff were required to record the purpose of administrating PRN medication and what effect it had on the resident's behaviour. However, some staff were not completing or updating these records and where this

was the case, there was no record as to why the medication was administered or what effect (if any) it had on the resident. Therefore, the documentation did not always demonstrate that these medications were consistently used as intended.

Due to issues related to behaviours of concern a number of safeguarding plans were in place for some residents. Staff also had training in safeguarding vulnerable adults and, from talking to two staff members over the course of this inspection, the inspectors were assured that they had the competence and knowledge required to respond appropriately to any issue of concern arising in the centre. However, as outlined in the capacity section of this report, quarterly notifications from the centre received by HIQA informed that there was a high level of minor injury and, or bruising occurring to residents (some unexplained). While the provider gave some reassurances to HIQA regarding these concerns, the process of reviewing and investigating these issues so as to ensure residents were adequately safeguarded, did not commence in a timely manner and required further review. Ultimately, due to the institutional nature of the service and the mix of residents accommodated, residents continued to be at risk of experiencing poor safeguarding outcomes.

Residents were also subject to a number of institutionalised practices which impacted negatively on their rights and freedoms as citizens. For example, the design and layout of the premises did not provide for an appropriate living environment which was suitable for 16 adults with disabilities. The design and layout did not provide a homelike environment and impinged on residents' rights to privacy and dignity. There was inadequate private accommodation available to residents and a number of residents had no alternative but to sleep in dormitories (with four male residents sharing one dormitory and five female residents sharing the other). The templates used for residents' individual personal plans referred to them as 'in patients'. Residents were not permitted to access parts of the premises. For example, there was a large industrialised kitchen on the premises which residents were not permitted to access or use. It was also observed that the residents' dining room was being used daily to provide meals to people using a nearby day service that did not live in the centre.

Residents' rights to their own property was restricted. Residents had inadequate control over their finances and were only permitted to keep €25 in their individual wallets or purses. If a resident required over €25 (for example to buy clothes or avail of an outing), they had to put a request into management documenting how much they needed and why they required additional access to their own personal money. Residents were not facilitated to avail of some community-based activities of interest in Northern Ireland (a short drive away) as the arrangements in place did not permit residents to use Sterling. The inspectors saw that this directly impacted on freedoms and rights in a number of areas which would not be experienced by their peers in the community. For example, these arrangements resulted in one resident being unable to access a nearby swimming pool for the last two years (an activity that they enjoyed) as the pool was located across the border.

There were systems in place to manage and mitigate risk in the centre. However,

the risk management process required review as some of the mitigating factors identified as 'required additional controls measures' to mitigate some risks, were not in place. For example, (and as already stated in this report) additional behavioural specialist support and psychology input were required to mitigate the risk related to behaviours of concern. These supports where not in place at the time of this inspection. This was of concern to the inspectors as a number of the residents required a significant level of intervention and support for the management of challenging behaviour.

The inspectors reviewed the arrangements in place to keep residents safe from the risk of fire. There were systems in place to ensure all fire fighting equipment (such as, fire panel and emergency lighting) were serviced quarterly. Fire extinguishers were serviced annually. A sample of documentation informed the inspectors that staff undertook weekly checks on all fire fighting equipment and escape routes. Fire drills were held regularly and all residents had a personal emergency evacuation plan in place. However, some aspects of fire safety precautions required review to ensure there was adequate and timely means of escape from the centre in the event of a fire. For example, the most recent fire drill, conducted 22 May 2019, informed that there were difficulties evacuating one resident (due to an issue with a piece of equipment required for the evacuation) and it took 20 minutes to evacuate all residents from the centre. The resident's personal emergency evacuation plan had not been updated to reflect this delay and at the time of this inspection the provider could not demonstrate that in the event of a fire, they could evacuate all residents from the building in a timely manner.

There were procedures in place for the safe ordering, storing, administration and disposal of medicines which met the requirements of the Regulations. PRN (as required) medicines, where in use, were kept under review and there were protocols in place for its administration. There were also systems in place to respond to and learn from any drug errors occurring in the centre. An issue with the recording system in place for PRN medication was identified and this was discussed earlier in this report.

Overall, this inspection found that many aspects of the quality and safety of care provided to the residents did not meet the requirements of the regulations, residents were subject to institutionalised practices, they were not being supported to have meaningful and active lives in their community and residents' rights to privacy and dignity were compromised and the process of managing risk required review.

Regulation 13: General welfare and development

The systems in place to ensure residents had access to a range of facilities for recreation purposes based on their interests and preferences was insufficient and

access to community-based facilities was limited.

Judgment: Not compliant

Regulation 17: Premises

The premises were institutional in design, not suited for their stated purpose and did not promote or protect the privacy and dignity of many residents living there.

Judgment: Not compliant

Regulation 26: Risk management procedures

The risk management process required review as some of the mitigating factors identified as required additional controls to mitigate some risks were not in place.

Judgment: Not compliant

Regulation 28: Fire precautions

The systems in place for evacuating all residents from the centre required review as on the last fire drill evacuation of the centre was not demonstrated adequately. This issue was not addressed at the time of this inspection. One resident's personal emergency evacuation plan also required updating and review after this fire drill.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were procedures in place for the safe ordering, storing, administration and disposal of medicines which met the requirements of the regulations.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The supports in place for residents to achieve personal and social goals and enjoy regular access to their community and community based activities required review. There were prolonged periods of time where residents were not leaving the centre to avail of community-based activities.

Judgment: Not compliant

Regulation 6: Health care

The inspectors were satisfied that residents' health needs were being comprehensively provided for with appropriate input from allied healthcare professionals as and when required. Residents also had regular access to GP services, their medication requirements were being reviewed and hospital appointments were being supported and facilitated as and when required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors observed that the residents had access to psychiatry support and where required had a positive behavioural support plan in place which were reviewed accordingly.

However, some staff required refresher training in the management of positive behavioural support.

The process of recording the administration of PRN medication to manage behaviours of concern also required review as it was inconsistent. Some staff were recording all the required information pertaining to PRN medication while some were

not recording this information.

Judgment: Substantially compliant

Regulation 8: Protection

Where required residents had safeguarding plans in place. Staff were knowledgeable about residents' needs and from a sample of files viewed, they had undertaken training in safeguarding of vulnerable adults and Children's First training.

However, the process of adequately investigating some safeguarding issues as identified in quarterly notifications to HIQA did not commence in a timely manner and residents were also subject to a number of institutionalised practices as detailed in the main body of this report.

Due to the institutional nature of the service and the mix of residents accommodated, residents continued to be at risk of experiencing poor safeguarding outcomes.

Judgment: Not compliant

Regulation 9: Residents' rights

The designated centre was institutional in design and did not promote the rights of the residents. Residents' right to privacy and dignity was compromised, they did not have access to parts of the centre, had inadequate control over their personal finances and could not access services of interest to them across the border in the same way as their peers.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for James Connolly Memorial Residential Unit OSV-0002502

Inspection ID: MON-0023789

Date of inspection: 06/06/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The duty roster at the centre has been reviewed resulting in revised delegation of duties within existing resources to maximise socialisation opportunities for all residents, for example; personal shopping, dining out and family visits. Completed 2nd July 2019.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff scheduled to complete behaviour management training, inclusive of positive behaviour support by 30th August 2019.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
An unannounced 6 monthly visit was completed on 12th March 2019. Following receipt of feedback the recent HIQA inspection in the James Connolly Memorial
Residential Unit, a further unannounced visit has been completed on 16th July 2019 by provider nominee representative; all actions identified will be addressed through the quality improvement process (QIP) by the PIC and PPIM and staff team.

The Provider Representative has reviewed the oversight arrangements in the centre. The current arrangements consist of;

· Quarterly Self Assessment using the Judgement Framework
· Quality Improvement Plan
· Annual Schedule of Audit
· Six Monthly unannounced Provider Nominee Visits
· Annual Review by the Provider Nominee

Governance and Oversight within the center will be further strengthened by the following actions:

Quarterly Self- Assessment
The Person in Charge completes a Quarterly self assessment against the judgment framework from which the Centre's Quality Improvement Plan is developed. This process will be supported by the Director of Nursing. Further upskilling of the center's management in relation to the accurate completion of self assessments will be supported by the Regional DON. This will be completed by August 15th 2019.

Quality Improvement Plan
On site verification by Senior Management to ensure actions are closed out within set time frames and to review/examine the information contained within the monthly audits, review of quality and safety of care and self assessments against practices observed and documented in the centre
The Provider Representative has requested the QIP be reviewed by the GM office on a weekly basis to strengthen oversight and governance and improvements. As part of this an onsite visit will be conducted by the Regional Director of Nursing on a fortnightly basis for one month, and a monthly visit for 3 months and then reviewed

Annual Schedule of Audit:
Audits will be carried out in line with the audit schedule. Audit outcomes and actions identified will form part of the overall quality improvement plan. Strict time frames will be adhered to. The audits will be reviewed as part of the external visits by Senior Management.

6 monthly unannounced Visits / Annual Review:
The Provider Representative will conduct a critical review of the process involving 6 monthly and annual reviews by carrying out unannounced visits to ensure the accuracy of the information collected. The Provider Representative, in conjunction with Regional Director of Nursing will complete the next 6 monthly unannounced visit and annual review for the centre.

Quality Safety & Risk Meetings will be held Quarterly by Director of Nursing, to provide oversight with regard to Incident Management, Risk Management and Safe delivery of Services. The Provider Representative maintains a risk register which is escalated to senior management through Quality Patient Safety Dept on a quarterly basis.

Further announced / unannounced visits will be undertaken by the Clinical Nurse Manager III for Quality Risk and Service User Safety throughout the year to provide additional assurance in relation to overall compliance.

Fortnightly teleconferences with all Service Managers / Director of Nursing facilitated by Social Care Lead / General Manager, will continue.

Bruising:
All bruising of residents within the center has been reviewed in relation to the possible cause and prevention of further bruising occurring. A reduction in bruising has been recorded in the designated centre. In Qrt 1 there were 23 bruises recorded and this has reduced to 16 in Qrt 2. This indicates a 26% reduction between the two periods. Staff awareness has been heightened and observation of the residents will continue in order to ascertain the causes of bruising if not already identified. The ultimate goal is a reduction in bruising.

The Occupational Health Department are providing additional support to the centre, their Manual Handling Advisor will facilitate a Manual Handling Workshop in the centre to review practices and advise as necessary. This will be completed on 07th August 2019.

In addition, local GPs have also been requested to review each of the residents paying particular attention to their blood profile and those at risk of bruising due to their physical status. All advice from the GP will be followed in full.

An ongoing environmental review will take place in relation to the potential environmental causes of bruising and thus assist with prevention. This will be complete before the end of August 2019.

In relation to premises please note response under Regulation 17.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose has been reviewed. A planned schedule of weekly social activities, to include access to ordinary places for all residents living in the centre has been developed and implemented to ensure services are being delivered in line with the Statement of Purpose.
Completed 15th July 2019.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A planned schedule of weekly social activities, to include access to ordinary places, has been developed and implemented to ensure all residents have maximum opportunity to engage in their community. The schedule identifies what activities have been offered and what activities residents have chosen to undertake.
Completed 16th July 2019.
Resident's enjoyment levels of these activities are recorded to ensure effective evaluation of their participation with social activities identified.
Commenced 16th July 2019.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The HSE has agreed 10 priority sites for decongregation with HIQA including 2 facilities in CHO1. These 10 priority sites remain the overall priority and are proceeding. It is the intention to agree the next group of priority sites nationally with HIQA, and, in that regard, CHO 1 will be putting forward a business case in respect of JCM. The National Director of Community Operations will support that case through the estimates process.

On the basis that if this successful through the estimates process, and JCM is prioritised for Decongregation within the assigned resources, the following planned moves will take place.

• Four people will move to a house within the community from June 2020.
• An additional 4 people will also transition to a house in the community by November 2020. Again this is fully dependant on availability of resources.

This will leave 8 remaining residents within the facility and privacy and dignity will maintained for those people. Application will be made through the 2021 estimates to complete the decongregation of JCM. Again this will be dependant on available resources.

An Individual Assessment of Need has been completed in terms of future accommodation for all residents including OT assessment, compatibility assessments which will be

recommenced in order to ensure that people will be suited to live with each other. The transition plan will be completed closer to the time once funding has been fully secured and the premises is ready.

Planned improvement for JCM
· The building will be painted internally to include all communal areas, dining areas, hallways, bathrooms and bedrooms on the ground floor. These areas will be painted and decorated in line with resident's wishes to ensure that these are personalised to reflect each individual's wishes.
These works will be completed by 30th November 2019.
· The dormitory style bedrooms have been reviewed by the HSE Donegal Estate's Project Manager and a proposed bedroom upgrade developed (Copy attached). This will enhance privacy and dignity for residents.
These works will be completed by 30th November 2019.

Management have met with the staff team and agreed the following;

· Key workers will support the individual residents to personalise their living areas to include bedrooms, bathrooms and communal areas. Initial focus will be on the purchase of individualised items to include pictures and soft furnishings for the bedroom areas. To be completed by 21st August 2019.
· Bespoke signs to further enhance privacy & dignity of residents are displayed on bedroom doors. Complete 17th July 2019.
· Replacement mobile screens have been ordered to ensure privacy and dignity is maintained at all times on the main corridor to facilitate movement from bedrooms to bathrooms for personal care. Expected date of delivery 30th August 2019.
· The dining room in this centre is no longer being used to facilitate individuals from a nearby day service Completed 16th July 2019.
· All residents continue to have full access to their dining room and a kitchenette at all times within the centre. Completed 16th July 2019.

Senior Management Social Care CHO1, have again liaised with Local Estates CHO1 and have requested any further potential upgrade to the initial plan as submitted in the recent response to HIQA. Unfortunately, due to fire restriction / safety, any further attempt to adapt the large bedrooms is not possible. The original plan is therefore the only option available to us at this time. We note that this is not the ideal option as is indicated by the Authority, however, the HSE has been directed to remain within its allocated resources and as such must support the original plan.

The Inspector has reviewed the provider compliance plan. These actions proposed to address the regulatory non-compliance do not adequately assure the Office of the Chief Inspector that the actions will result in compliance with the regulations.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All risks, including 'additional controls required' in place for this centre reviewed and updated. Completion date 19th July 2019.
Risks identified in relation to MDT specialist support have been escalated to the Donegal Intellectual Disability Risk Register. Completion date 7th June 2019.
In relation to multi-disciplinary input for this centre, psychology services have been obtained (3rd July 2019). Detailed assessments, recommended by Senior Psychologist, are being completed for two residents who have behaviours of concern. The behaviour support plans and the completed assessments will be reviewed on site by Senior Psychologist on 30th July 2019.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Systems for evacuating residents have been reviewed. The issue which resulted in delayed evacuation on May 22nd2019 has been closed (17th June 2019).
All PEEP's have been reviewed and updated where necessary (17th June 2019).
A simulated night time compartmental evacuation drill took place on 21st June 2019. Successful evacuation completed.
Compartmental evacuation drills are scheduled monthly (commenced on 21st June 2019).

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:
Following review and revision of all residents personal plans, arrangements are now in place to meet the assessed social needs of each resident. Each resident has a planned weekly schedule of community-based activities. Completed 15th July 2019.
The duty roster at the centre has been reviewed and revised with a delegation of duties to ensure that all residents are supported to access community-based facilities for social and recreational purposes. Completed 2nd July 2019.
Plans for resident's holidays will be finalised by 23rd August 2019 in accordance with resident's individual wishes and preferences.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The recording practice in relation to the administration of PRN medication to support residents with behaviours of concern has been reviewed. The purpose of administrating PRN medication is documented in the individual's Behaviour Support Plan/Careplan. Nurses will record the steps taken prior to the administration of PRN Medication and the effectiveness of the PRN medication in the Nursing notes to avoid duplication. Effective from 16th July 2019.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All residents have Personal Plans. NIMS are reviewed individually by the PIC and will be audited monthly by the PIC or CNM1. Commenced July 2019.
The resulting action plans will be discussed and reviewed at the quarterly Inishowen Network Area Management meetings. PIC is responsible for implementing recommendations.
Analysis of NIMS has been completed by the quality and patient safety department (CHO1) in preparation for a multi-disciplinary meeting on 23rd July 2019.
This multi-disciplinary meeting including quality and patient safety and safeguarding has been arranged to review incidents and incident management within the centre.
In addition quality and patient safety CHO1 social care lead will provide training on Incident and Risk Management for staff at the centre on 23rd July 2019.
The CNM2/PIC will attend 'After Action Review' training, scheduled for September/October 2019 (date TBC).
Following completion of MDT review on 23rd July 2019, actions identified will be addressed by the PIC and PPIM to ensure residents are adequately safeguarded.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
As above in relation to the use of dormitory style bedrooms, the plan submitted has attempted to provide additional privacy and dignity for the residents. Unfortunately due to fire restriction any further attempt to adapt the large bedrooms is not possible at this time.
In addition :
Bespoke signs to ensure residents privacy & dignity of residents are displayed on bedroom doors. Complete 17th July 2019.
All staff including cleaning staff have been communicated with in relation to the importance of privacy and dignity of the residents while carrying out their duties.
Replacement mobile screens have been ordered to ensure privacy and dignity is maintained at all times on the main corridor to facilitate movement from bedrooms to bathrooms for personal care. Expected date of delivery 30th August 2019.

Kitchen:
While residents do not have access to the large industialised kitchen, which is a main production HACCP kitchen, there is a small kitchenette which is available for residents to use. The main production H.A.C.C.P kitchen can only be used by trained staff who have been trained in the use of Industrial catering equipment, and have been trained in Food safety matters and completed a Management of Food Hygiene Course. All staff who work in this area have been trained in the use of this type equipment, as there are Health and safety risks associated with this equipment. All staff who work in this area must adhere to a strict dress code to comply with Health & Safety and Food Safety Legislation. It must also must be compliant with relevant legislation as below.

Regulation (EC) 852/2004 on the Hygiene of Foodstuffs
EC (Hygiene of Foodstuffs) Regulations 2006 – 2018
Regulation (EC) 178/2002 on the General Principles and Requirements of Food Law
EC (General Food Law) Regulations 2007 - 2012
Regulation (EU) No. 1169/2011 on the Provision of Food Information to Consumers
Health (Country of Origin of Beef) Regulations 2006-07
Food Safety Authority of Ireland Act 1998 and Associated Regulations
Food Hygiene Regulations 1950-89
Allergen Regulations Act 2017

Kitchenette:
In relation to the Kitchenette which is accessible to all residents, this is a well equipped facility which will facilitate normal domestic activities for each resident. The area is well maintained and has easy access for residents. The kitchenette is equipped as follow;

- 4 Ring Hob grill, and oven
- Fridge/ freezer
- Toaster
- Kettle
- Storage area
- Cupboards
- Sink
- Microwave
- Dishwasher

• Toaster sandwich maker
• Wash Hand

In relation to any restrictive practices within this center, the Restrictive Practice self assessment under the HIQA Thematic Inspection process will be under taken by 10th August 2019. Any action required will be carried out immediately.

All residents have a financial capacity assessment completed. All residents in the centre require full assistance to manage their personal finances and have patient private property (PPP) accounts which are held centrally by the HSE in Tullamore, Co. Offaly.

Financial practices have been reviewed within the centre, each resident now has a cash balance held locally of €50 for day to day expenditure. From 24th July 2019 there will also be a balance of stg£25 for similar expenditure. Money is available for every resident in the administration office in the centre which includes use of a cheque book for their expenditure from their PPP accounts. Residents are supported by staff to access their personal monies in their PPP accounts, including at short notice if required.

The duty roster at the centre has been reviewed resulting in revised delegation of duties to ensure that all residents are supported to access community-based facilities for social and recreational purposes. Completed 2nd July 2019.

A planned schedule of weekly social activities, to include access to ordinary places, has been developed and implemented to ensure residents have maximum opportunity to engage in community living. Completed 2nd July 2019

The centre has adopted a new computerised care management system. The centre had full access to the new system form 11th July 2019. Unlike the former system the new system does not make reference to the term 'in patients' on the template of personal plans. The process for transferring information to the new system will be completed by 31st October 2019.

The Inspector has reviewed the provider compliance plan. These actions proposed to address the regulatory non-compliance do not adequately assure the Office of the Chief Inspector that the actions will result in compliance with the regulations.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Red	08/08/2019
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Red	08/08/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the	Not Compliant	Red	08/08/2019

	statement of purpose and the size and layout of the designated centre.			
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	30/08/2019
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 objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/11/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/11/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Red	08/08/2019
Regulation 23(1)(c)	The registered provider shall ensure that	Not Compliant	Red	15/08/2019

	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.			
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	Red	08/08/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	08/08/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	08/08/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Red	08/08/2019
Regulation 05(3)	The person in charge shall ensure that the designated centre	Not Compliant	Red	08/08/2019

	is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	02/07/2019
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.	Substantially Compliant	Yellow	30/08/2019
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	30/08/2019
Regulation 07(4)	The registered	Not Compliant	Orange	16/07/2019

	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.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/08/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Red	08/08/2019
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	Red	10/08/2019
Regulation 09(3)	The registered provider shall ensure that each resident's privacy	Not Compliant	Orange	30/11/2019

	and dignity is respected in 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.			