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:	Railway View & Finnside
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Announced
Date of inspection:	01 and 02 August 2019
Centre ID:	OSV-0005488
Fieldwork ID:	MON-0027562

About the designated centre

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

Railway Finnside provides 24 hour full-time residential support to both male and female residents some of whom have complex support requirements. The centre can accommodate 11 adults and comprises of two detached bungalows which are located on a small campus based setting. There is a centralised kitchen on the campus from which meals are provided to the residents. There is also a day service where residents can attend. The campus is within walking distance to a large town in Co. Donegal. Two service vehicles are provided to accommodate residents' access to community based facilities also. Each resident has their own bedroom. Both bungalows have considerable collective space and spacious gardens. The centre is staffed on a 24/7 basis with a full time person in charge (who is a clinical nurse manager II), a team of staff nurses and a team of health care assistants. The staffing arrangements include four staff on duty each day and two staff on waking night duty in each unit when all of the residential places are at full capacity. Access to GP services and other allied healthcare professionals form part of the service provided to the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
01 August 2019	14:30hrs to 19:00hrs	Anna Doyle	Lead
02 August 2019	08:00hrs to 13:40hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

The inspector met all of the residents living in the centre and spoke with some of them to see their views on what it was like to live there. Some residents did not wish to talk to the inspector and this was respected.

Of the residents met, they expressed that they were happy living there. One spoke about an activity they had been on that day which involved pet therapy(an activity that was important to this resident). Some of the residents went out for dinner on the first day of the inspection.

Staff were observed supporting residents in a kind and patient manner and residents appeared relaxed in the company of staff. It was evident from interactions observed that the staff on duty knew the residents well. For example; they indicated to the inspector when a resident may not want to engage with the inspector.

Staff were also observed supporting residents to make hot drinks when they wanted one and to support them with some household activities that residents liked to do.

Capacity and capability

This inspection was conducted following an application by the provider to the Health Information and Quality Authority (HIQA) to vary the conditions of registration to increase the occupancy of the centre from 11 to 12 residents. The inspection was also to assess ongoing compliance with the regulations.

The inspector found that the governance and management systems in place were not effective in ensuring the service provided to the residents was safe or adequately resourced. Issues were also found with the staffing arrangements and with notifications of incidents.

A planned and actual rota was maintained in the centre. A staff member was appointed as the shift lead during the day and at night. The person in charge and the director of nursing provided out of hours cover to support staff. However, at the time of the last inspection in August 2017, it was identified that there were insufficient staffing levels at certain times in the centre in order to support the residents' needs. A risk assessment dated July 2017 outlining that additional staff was required in both units between the hours of 8pm and 11pm had not progressed at the time of this inspection. The inspector was informed that the additional staff

had not been provided due to a resource issue. There had been no other options explored and no records to demonstrate that the provider had taken any alternative actions to address this risk.

Another risk assessment dated February 2019 which had also been submitted to the provider outlined the need to provide one to one support for a resident who was at risk of falls. The inspector found that this one to one support had not been provided until 25th March 2019 after the resident had sustained another significant injury as a result of a fall. A further risk assessment completed by the person in charge and submitted to the provider outlined the need to employ a behaviour specialist due to the level of incidents occurring in the centre. This had not progressed either at the time of this inspection.

While some staff vacancies had been filled in the centre, there was still an over reliance on agency staff to cover unplanned leave. One roster viewed found that 20 shifts had been filled by agency staff in the centre. The staffing levels in one unit were also inconsistent. For example; some days only two staff were on duty from 6pm – 8pm in the evening times to support residents despite the fact that three staff were required. In the other unit, there were times when residents could not be facilitated to go on planned outings due to the staffing levels in the centre.

The inspector also found that a staff member from each unit was appointed each day to respond to emergencies in other designated centres on the campus. This had not been risk assessed and it was unclear given the assessed needs of the residents how this was being managed safely.

The inspector was therefore not satisfied that the staffing levels in the centre were adequate to meet the needs of the residents or that the provider was responding to risks identified in the centre.

The provider had made appropriate arrangements for the key management post of person in charge. They were a qualified nurse and had the necessary skills and experience required to meet the requirements of the regulations. They were full time in the centre and demonstrated a good knowledge of the residents' needs and were responsive to any issues raised during the inspection. They reported to a Director of Nursing (DON) who in turn reported to the disability manager for this area.

The person in charge reported they felt supported in their role and had daily contact with the DON in order to discuss the care and support needs in the centre. However, they had no minutes of meetings recorded and it was unclear who was accountable for any areas of service improvement required.

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 identify some of the issues found at this inspection, particularly in relation to the staffing levels in the centre. The annual review completed for 2018 did not include consultation with residents' representatives either.

The person in charge also conducted a number of other audits in the centre such as restrictive practices, personal plans and health and safety. These audits were ensuring that the services provided were identifying areas for improvement. For example; risk management training had been identified as being required for all staff and the person in charge was progressing this action.

Of the staff met, they said they felt supported in their role and were able to raise concerns with the person in charge when required. Staff meetings were conducted in each home every two months. The person in charge attended these meetings. Records of the meetings indicated that areas of service improvement were discussed and accountable persons were nominated to complete required actions if needed. For example; as discussed risk management training identified through a health and safety audit was discussed and person in charge was arranging this. An annual performance development review had also been conducted with staff. From a sample viewed, areas such as training needs for staff were discussed.

Staff had been provided with training in fire safety, positive behaviour support, safeguarding, hand hygiene and the use of specialist transport equipment. The person in charge had a quality improvement plan which outlined that further training needs identified was due to be completed in 2019. Some of this training included Cardio Pulmonary Resuscitation (CPR) training, further training in positive behaviour support, risk management and human rights.

A sample of personnel files reviewed found that they contained the requirements under the regulations. This included up to date Garda vetting forms which had been an action from the last inspection.

The inspector discussed the admission criteria to the centre for new residents with the person in charge and the DON. There had been no one identified for the proposed vacancy at the time of this inspection should the application to increase the occupancy be granted. The DON outlined that the provider would be assessing the staff supports required for any new residents prior to their admission to the centre. Improvements were required to ensure that the admission criteria included in the Statement of Purpose outlined the criteria to ensure residents were adequately safeguarded prior to any new admissions to the centre (this is addressed under that regulation).

At the time of the inspection all of the contracts of care had been reviewed by the provider to reflect changes to the fees charged to residents. They had been sent to the residents representatives to be signed and therefore were not available in the centre for review.

Regulation 14: Persons in charge

The person in charge in the centre was a qualified professional (Clinical Nurse Manager) with significant experience of working in and managing services for people

with disabilities.

They demonstrated a good knowledge of the residents' needs in the centre and was also aware of their 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

There was an over reliance on agency staff to cover unplanned leave in the centre.

A staff member from each unit was appointed each day to respond to emergencies in other designated centres on the campus. This had not been risk assessed and it was unclear given the assessed needs of the residents how this was being managed safely.

The staffing levels in one unit were also inconsistent. Some days only two staff were on duty from 6pm – 8pm in the evening times in one unit to support residents despite the fact that three staff were required.

There were times when residents could not be facilitated to go on planned outings due to the staffing levels in the centre.

A risk assessment dated July 2017 outlining that additional staff was required in both units between the hours of 8pm and 11pm had not progressed at the time of this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had been provided with training in fire safety, positive behaviour support, safeguarding, hand hygiene and the use of specialist transport equipment. The person in charge had a quality improvement plan which outlined that further training needs identified was due to be completed in 2019. Some of this training included CPR training, further training in positive behaviour support, risk management and human rights.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre which included the details required under the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place were not assuring effective oversight of the centre to ensure that it provided a safe service to the residents and was adequately resourced. Audits did not identify some of the issues found at this inspection particularly in relation to the staffing levels and the provider was not responding appropriately to risks identified in the centre.

The annual review completed for 2018 did not include consultation with residents' representatives.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspector was satisfied that the providers admission criteria met the requirements of the regulations.

At the time of the inspection the all of the contracts of care had been reviewed by the provider to reflect changes to the fees charged. They had been sent to the residents representatives to be signed and therefore were not available in the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The Statement of Purpose for the centre contained all of the information required under the regulations. Improvements were required to ensure that the admission criteria included the need to protect all residents from abuse prior to any new

admissions to the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Two incidents which had been reviewed and followed up by the person in charge had not been notified to HIQA in line with the regulations.

Judgment: Substantially compliant

Quality and safety

This inspection found that residents were being supported to engage in meaningful activities. However, the quality and safety of care provided to the residents required review and improvement. As already discussed in this report, the provider was not adequately responding to risks identified in the centre or ensuring that adequate staffing arrangement were in place to meet the assessed needs of the residents. As a result improvements were required under a number of the regulations inspected to ensure a safe quality based service for the residents. The inspector also found that improvements were required under residents rights and premises.
Additionally, improvements were also required with personal plans, health care, fire safety and safeguarding.

The premises were for the most part clean and well maintained. At the time of the inspection all of the bathrooms in the centre were either in the process of being refurbished or were due to be done. One bathroom which had been refurbished had been finished to a high standard and had been adapted to suit the needs of the residents in the centre. Some other repair works were required however, the person in charge outlined that these would be completed once all bathrooms had been refurbished. All of the residents had their own bedrooms which had been personalised to their individual tastes.

There was a small kitchen in both of the units where residents could prepare small meals. However, meals were provided from a large centralised kitchen. Therefore the kitchen was not accessible to residents to prepare their own meals in the centre. In addition, there were large food serving plates stored in both dining rooms when meals were not being served which did not promote a home like environment.

Each unit had a number of communal areas for residents. One unit was well decorated and homely but two of the communal areas in one of the units required improvements to make it more homelike and comfortable for residents. Both units had large outside areas with seating provided for residents use. Residents were able

launder their own clothes if they wished and enjoyed helping with household chores.

A record of equipment used in the centre was maintained. A sample of records viewed found that equipment such as hoists and specialised mattresses had been serviced this year. However, an assessment conducted in January 2019 recommending a specific bed for one resident had not been provided for at the time of the inspection.

Improvements were required to ensure that residents rights were upheld. A sample of records viewed found that while residents potential views were considered as part of decisions around their care and support, this was not implemented in line with the Health Service Executive Consent policy. Residents did not have their own bank accounts. Their monies were managed through a patient property account. This meant that residents had to apply to administration staff to get their own money on a weekly basis. The residents also did not have access to any financial records which would inform them of the amount of money that they held in their personal property account. The inspector found that this was not respecting the rights of the residents in the centre.

Residents who required support around behaviours of concern had a behaviour support plan in place to guide practice. The person in charge informed the inspector that a psychologist and staff nurse (trained in positive behaviour support) reviewed behaviour support plans every six months. However (as already stated in this report) a risk assessment had highlighted the need for a behaviour specialist to further support residents in this area. This had not progressed at the time of this inspection.

A sample of support plans viewed by the inspector also found that some behaviours were not referenced in the plans and therefore no interventions were in place to guide staff practice. For example a resident who engaged in self-injurious behaviours did not have it outlined in the plan how best to support them. Some residents were also prescribed medications (chemical restraint) in response to behaviours of concern, however the behaviour support plans or medication protocols in place did not fully guide practice in this area.

While there had been a marked reduction in the amount of incidents occurring in the centre in the last month which provided some assurances that residents were being supported, the systems in place still required review to assure that this was maintained in the future.

The inspector also found that while record logs were maintained when restrictions were implemented in the centre, improvements were required in the records maintained for some of these restrictions to ensure that they were reviewed, consented to and that there was a clear rationale for the implementation of these.

Each resident had a personal plan in place. From a sample viewed they included an up to date assessment of need. An annual review had been conducted where goals had been developed for residents. For example; some residents were planning a short vacation for later in the year and another resident had been supported to go to a religious shrine. Residents were being supported to increase their independent living skills through skills teaching programmes. However, the records were not

consistently maintained meaning that residents' progress could not be evaluated.

Residents had access to the use of a day activation unit located on the grounds of the campus. On review of a sample of residents' records they were supported to access meaningful activities during the day. For example, they went swimming, out for coffee, equine therapy, drives and walked to the local shops.

However, in one unit, the assessed needs of the residents were found to impact residents opportunities for meaningful activation. For example; some residents required 2 to 1 support while out in the community leaving only 2 staff to support the other five residents. On the second day of the inspection one resident could not be supported to avail of a planned activity as a result of this.

Each resident had timely access to allied health care professionals in relation to their assessed health care needs. This included a general practitioner (who visited the centre weekly) a psychiatrist, psychologist, occupational therapist speech and language therapist. Plans of care were in place to guide staff on how to support the resident. These plans were reviewed by nursing staff in the centre.

Residents had been supported to access National Health Screening programmes but improvements were required in how residents consented to these procedures (as discussed under rights). There was evidence to support that residents had the right to refuse some treatment interventions. However, staff were not clear when this should be notified to the prescribing doctor and there was no written guidance in place to support this practice either.

There were risk management systems in place in the centre and as discussed in Section One of this report the provider was not responding to identified risks appropriately.

A health and safety statement available in the centre, included appendices where risks were identified and risk assessed. Residents had individual risk assessments in place. The provider had systems in place to audit these practices. For example; a health and safety audit had been conducted in May/June 2019. The report from this audit had not been finalised at the time of the inspection. However, the person in charge stated that there were no major findings from this audit. The person in charge reviewed all incidents that occurred in the centre and risk management was discussed at staff meetings to inform learning.

All staff had been provided with training in safeguarding vulnerable adults. Staff met were aware of what constituted abuse, the reporting procedures in place and how best to support the resident in such an event. A number of notifications had been submitted to HIQA in relation to allegations of abuse. The inspector found that there was good oversight by the person in charge of these incidents in the centre. For example monthly safeguarding meetings were conducted to review any incidents. These meetings were attended by social workers, a psychologist and the person in charge. Safeguarding plans had been developed to ensure that residents were safe. However, one incident that had been reported in April 2018 had not been investigated by the provider in a timely manner. At the time of this inspection the

investigation had not begun into this incident.

A sample of intimate care plans viewed found them to be detailed and outlined the individual preferences of the residents

There were fire safety arrangements in place in the centre which included the provision of fire doors, means of escape, emergency lighting, a fire alarm and fire fighting equipment. Staff undertook weekly and monthly checks on all fire fighting equipment and escape routes. The records viewed in one community home demonstrated that all equipment was serviced appropriately and that staff undertook weekly and monthly checks on all fire fighting equipment and escape routes. All staff had completed training in fire safety.

Personal emergency evacuation procedures (PEEP) had been developed for each resident outlining the supports they required for a safe evacuation of the centre. Fire drills were conducted to ensure a safe evacuation of the centre. The records viewed indicated that residents could be safely evacuated from the centre in a timely manner. However, some aspects of these fire safety precautions required review to ensure a timely means of escape from the centre in the event of a fire. For example, one residents PEEP did not fully outline the supports required when their health declined (this was not an issue at the time of the inspection). The fire drill conducted as a night time drill did not detail how the fire drill was conducted. For example; whether residents were in bed at the time of the fire drill.

Regulation 13: General welfare and development

Some residents did not have access to meaningful activities in the centre due to the staffing levels and assessed needs of other residents.

Judgment: Substantially compliant

Regulation 17: Premises

Meals were provided from a large centralised kitchen. Therefore the kitchen was not accessible to residents to prepare their own meals in the centre.

Large food serving plates were stored in both dining rooms when meals were not being served which made the areas look institutionalised.

Two of the communal areas in one of the units required improvements to make it more homelike and comfortable for residents.

An assessment conducted January 2019 recommending a specific bed for one

resident had not been provided at the time of the inspection.

Some other repair works were required which will be completed once the bathroom had been refurbished.

Judgment: Not compliant

Regulation 26: Risk management procedures

The risk management systems in the centre required review to ensure that the provider responded to identified risks in a timely manner and to assure that risks had been mitigated.

A risk assessment had highlighted the need for a behaviour specialist to further support residents in this area. This had not progressed at the time of this inspection.

Records submitted after the inspection indicated that the two vehicles used in the centre had up to date road worthy certificates and were insured.

Judgment: Not compliant

Regulation 28: Fire precautions

One residents PEEP did not fully outline the supports required when their health declined.

The fire drill conducted as a night time drill did not detail how the fire drill was conducted. For example; whether residents were in bed at the time of the fire drill.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place. From a sample viewed they included an up to date assessment of need. An annual review had been conducted where goals had been developed for residents. For example; some residents were planning a short vacation for later in the year and another resident has been supported to go to a religious shrine.

Residents were being supported to increase their independent living skills through skills teaching programmes. However, the records were not consistently maintained meaning that residents' progress could not be evaluated.

Judgment: Substantially compliant

Regulation 6: Health care

There was evidence to support that residents had the right to refuse some treatment interventions. However, staff were not clear when this should be notified to the prescribing doctor and there was no written guide in place to support this practice either.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Some of the behaviour support plans did not include all of the interventions to support residents.

Some residents were prescribed medications (chemical restraint) in response to behaviours of concern, however the behaviour support plans or medication protocols in place did not fully guide practice in this area.

Improvements were required in the records maintained for some restrictions to ensure that they were reviewed, consented to and that there was a clear rationale for the implementation of these.

While there had been a marked reduction in the amount of incidents occurring in the centre in the last month which provided some assurances that residents were being supported, the systems in place still required review to assure that this was maintained in the future.

Judgment: Substantially compliant

Regulation 8: Protection

One safeguarding incident in the centre had not been investigated by the provider in a timely manner.

Judgment: Substantially compliant

Regulation 9: Residents' rights

A sample of records viewed found that while residents views were considered as part of decisions around their care and support, this was not implemented in line with the Health Service Executive Consent policy.

Residents did not have their own bank accounts and their monies were managed through a patient property account. This meant that residents had to apply to administration staff to get their own money on a weekly basis.

Residents did not have access to any of their personal financial records which would inform them of the amount of money that they held in their personal property account. The inspector found that this was not respecting the rights of the residents in the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Railway View & Finnside OSV-0005488

Inspection ID: MON-0027562

Date of inspection: 01/08/2019 and 02/08/2019

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:
A review of staffing has been completed by the Person in Charge in conjunction with the Director of Nursing. As a result of this review a fifth member of staff has been rostered on duty for on average of four out of seven days per week which has ensured that staff levels are consistent and planned activities are facilitated . The Statement of purpose will be updated to reflect the additional staff hours in the centre to support the assessed needs of the residents.
The Person in Charge will complete a review of the activity schedule for all residents in conjunction with the residents and centre staff.
The revised schedules will be implemented to ensure that each resident has access to meaningful activities and sufficient staff to support them in completing same.

A review of the use of the personal alarm system is underway to identify the frequency of usage of this system and rationale for same.
A protocol will be developed to manage the response to personal alarm activation.
A risk assessment of the personal alarm system will be undertaken as part of this review.

Risk assessments in relation to staffing shortages will be updated.
The PIC will make every offer to use consistent agency staff.

The Person in Charge will ensure that the actual roster is updated on a daily basis to reflect all staff on duty in the centre.

In the event that an application to vary is approved for this centre, 2 residents will transition with four additional staff who currently work with and are familiar with the residents.
Transition plans will be developed to ensure a smooth transition to the centre.

Regulation 23: Governance and	Not Compliant

management	

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A written record of discussions between the Person in charge and the Director of Nursing has commenced to ensure clear accountability for areas of service improvement.

Further Training has been provided for the Provider Representative, Director of Nursing and Person in charge in relation to the completion of 6 monthly visits and Annual Reviews to ensure these visits identify clearly issues that require to be addressed in the centre.

Residents are afforded the opportunity to provide feedback on the quality and safety of care and support as part of the centres' annual review and 6 monthly provider visits.

Direct consultation will take place with a selection of resident's representatives as part of all the next annual review planned for 30.11.2019 and all future annual reviews.

Weekly Residents meetings are held in the centre.

Satisfaction Surveys are circulated annually and staff support residents to complete these if required.

All residents' representatives are made aware of the local complaints policy and complaints officer.
A review of staffing has been completed by the Person in Charge in conjunction with Director of Nursing. As a result a fifth member of staff has been rostered on duty for on average four out of seven days per week which has ensured that staff levels are consistent, planned activities can be facilitated . The Statement of purpose will be updated to reflect the additional staff hours in the centre to support the assessed needs of the residents.

The person in charge completes a self assessment against the judgement framework on a quarterly basis. A Centre quality improvement plan is developed from this self assessment. The person in charge shares the quality improvement plan with centre staff and updates the plan on a monthly basis. This is monitored by the Director of Nursing. The centre quality improvement plan is submitted to the Provider representative via the Director of Nursing on a monthly basis for review.
There is an annual schedule of audit in the centre, which is completed by the person in charge. Actions arising from audits are added to the centre's quality improvement plan.
A health and safety audit has been completed and the actions from this audit have been incorporated into the centre's quality improvement plan.
There are 2 six monthly unannounced visits to the centre and one annual review. Actions from these visits are added to the centre's quality improvement plan.
Each resident living in the centre has an annual screening of risk factors (or more frequently if required). Risk assessments are completed if required by the Named Nurse. Risk assessments may be escalated via the nurse to the Person in Charge, Director of Nursing and on to the Provider representative if there are additional resources required to safety mitigate the risk to an acceptable level.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose has been updated on 31.08.2019 to include the actions that will be taken prior to an admission to this centre.
This includes:
• Compatibility assessment
• Transition Plan
• Consultation and discussion with residents at weekly residents meetings.
• Vetting and supervision of visiting therapists.

The Statement of purpose will be further updated to reflect the recent additional staff hours in the centre to support the assessed needs of the residents.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
2 retrospective notifications will be submitted to HIQA by 30.09.2019.
Where there is doubt in relation to the submission of some notifications the PIC will discuss with the Director of Nursing or the Provider Representative.
The Person in Charge will ensure that all three day notifications will be submitted to the Regulator within the specified time frame.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The Person in Charge will complete a review of the activity schedule for all residents. The revised schedules will be implemented to ensure that each resident has access to meaningful activities and sufficient staff to support them in completing same.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
There is a fully accessible kitchenette available in each home.
This is equipped with the following:
• Hob
• Grill & Oven
• Microwave
• Toaster
• Kettle
• Fridge/Freezer. Fridge is stocked with all items required for each resident
• Sandwich Toaster
• Food Processor
• Blender

• Baking equipment and utensils
• Smoothie maker
• Saucepans
• Frying Pan
• Individual snack boxes

Residents are provided with the opportunity to participate in skill building activities such as preparing light snacks e.g. toasted sandwiches, omelettes, scrambled egg, beans on toast, hot or cold drinks, baking small treats such as queen cakes, banana bread.
Breakfast is prepared in the centre and there is a wide range of options available based on individual preferred preference.
Dinner and evening meal are provided from a kitchen separate to the centre. There are 2 hot meal options available as well as soups and salads.
These meals are prepared by qualified chefs.
Meals are also provided for each resident based on assessed needs (SALT assessment and Dietetic recommendations)

A review completed by the Catering Manager on 23.09.2019 confirmed the requirement for the food serving plates as per HACCP guidelines.
The Person in Charge will source a storage unit for the serving plate which will complement the décor of the dining area.

Staff will consult with and support residents to enhance the décor within their home this will include the completion of repair works required within the centre on completion of bathroom upgrades.

With respect to an assessment conducted Jan 2019 recommending a specific bed for one resident, the following actions have been taken to date:
Discussion took place at local governance meeting on February 11th
2019 the outcome of which was that this resident prefers her current bed which is a larger bed, a further discussion will be held on this matter at the residents' MDT annual review which is scheduled to take place on October 2nd 2019.
All recommendations from this annual review will be implemented.

The service is at the early stages of planning for the development of a number of community based houses in conjunction with the County Council and Social Housing representatives. These houses will be equipped with kitchen which will facilitate residents to prepare their own meals.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
With respect to a Risk Assessment dated June 12th 2018 in respect of additional staffing required between 20:00 and 23:00, this was responded to by the Provider Representative to the Director of Nursing on 20.06.2018 with recommendations provided.

With respect to a risk assessment which highlighted the need for additional psychology input and support from a behaviour therapist, an additional Senior Clinical Psychologist was appointed to the Mental Health Intellectual Disability Team, and another Senior Clinical Psychologist was appointed to Donegal intellectual Disability Services on November 5th 2018.

A review of all Individual risks and Centre Risks will be undertaken by the Person in Charge in conjunction with Quality, Patient and Safety Committee on September 30th 2019 to ensure that all reasonable control measures are in place to mitigate the risk. Where additional controls are required which require additional resources or have a risk rating of 15 or more these will be escalated to the Disability Manager as per ID Risk Management Policy.
The outcome of the above review will be communicated to all staff in the centre.

All Staff in the Centre will attend Risk management training. The centre matrix will be updated to reflect this training.

A Health and Safety Audit conducted in May / June 2019 has been finalised and actions included in the centres quality improvement plan.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Personal emergency evacuation plan for one resident has been reviewed and updated to ensure that it provides clear guidance for all staff on the supports required when this residents' health declines.

All Personal emergency evacuation plans are updated at a minimum on an annual basis, or more frequently following fire drills as required.

Night time assimilated fire drills are conducted with the minimum amount of staff on duty. The Person in Charge will ensure that all future night time fire drills will detail whether residents were in bed or not.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Person in Charge will conduct an audit of a sample of personal plans to ensure that all records reflect the progress each resident is making in specific skills teaching programmes.
The outcome of this audit will be communicated all staff in the centre to ensure that they understand the importance of accurate record keeping to inform effective evaluation of progress.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

The Person in Charge in conjunction with Practice Development will develop a guide for staff to follow in the event that a resident should refuse treatment interventions. The guide will include the following:
• The documentation required
• The communication process required
The Person in Charge will arrange a review with the prescriber should a resident continually refuse prescribed treatment.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Two behavior support plans in the centre will be reviewed by Clinical Psychology and Multi element behavior support trained staff to ensure that the plan clearly identifies the target behaviour, and the interventions required to support them. The Behaviour support plan will clearly identify that "as and when required" prescribed medication are used for the therapeutic treatment of the underlying mental health issue rather than behavior. These will be communicated to all staff working in the centre.

The Person in Charge will conduct a review of the "as and when required" Medication Protocols to guide staff practice to ensure that all actions in the positive behavior support plan are attempted and documented before administration of the "as and when required" medication.

One crisis management plan will be reviewed with the resident concerned by the centre staff in conjunction with Multi-disciplinary team to ensure there.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
With regard to one incident referred to that had allegedly occurred in May 2018, all required documentation has been completed and submitted to the National Investigations unit of the HSE within the required timeframes under the HSE Trust in Care Policy.
This investigation is being managed by the National Investigations Unit, and is in process.
The PIC will inform HIQA of the outcome of this investigation upon completion.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Financial practices have been reviewed within the centre, each resident now has a cash balance held locally of €50 for day to day 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.

A quarterly financial statement is available for each resident.

Human Rights training has been delivered for a number of staff in the centre, the remaining staff will have completed this training by the end December 2019. The centre's training matrix has been updated to reflect this training.

As per the HSEs Consent Policy, all residents will be provided with easy read information and discussions with residents will be tailored according to :
• Residents' needs, wishes and priorities
• Residents' level of knowledge about, and understanding of, their condition, prognosis and the treatment options
• Residents' ability to understand the information provided/language used
• The nature of their condition

The Provider Representative will link with Nurse Practice Development to strengthen the existing will and preference document available in the service to include, as appropriate, the views of those who have close, ongoing personal relationship with the residents and the professional input from support staff and the Multidisciplinary team.

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)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	13/10/2019
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 statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	15/10/2019
Regulation 15(3)	The registered provider shall ensure that	Not Compliant	Orange	15/10/2019

	residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/11/2019
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Orange	30/11/2019
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly	Not Compliant	Orange	30/11/2019

	reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	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	Orange	31/10/2019
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	25/09/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	31/10/2019

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/11/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	15/10/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	04/08/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/08/2019
Regulation	The person in	Substantially	Yellow	02/08/2019

31(1)(f)	charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Compliant		
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.	Substantially Compliant	Yellow	15/10/2019
Regulation 06(2)(c)	The person in charge shall ensure that the resident's right to refuse medical treatment shall be respected. Such refusal shall be documented and the matter brought to the attention of the resident's medical practitioner.	Substantially Compliant	Yellow	31/10/2019
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Substantially Compliant	Yellow	15/10/2019

	to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
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.	Substantially Compliant	Yellow	15/10/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/05/2019
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	05/10/2019
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes,	Not Compliant	Orange	05/10/2019

	age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			