Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Dungloe Services 2
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	05 December 2022
Centre ID:	OSV-0002506
Fieldwork ID:	MON-0032881

About the designated centre

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

This residential service provides care and support to nine adults (both male and female) with disabilities. The centre is located in Co. Donegal and in walking distance to the local town. The home comprises a detached bungalow with a sitting room, fully equipped kitchen, a dining room, a utility room, one single occupancy bedroom with ensuite, four double occupancy bedrooms, a number of shared bathroom facilities and office facilities for the management and staff team. In addition, the centre has a separate isolation unit available in a nearby location for use during the COVID-19 pandemic, if required. There is ample private parking available at the centre and a large garden area to the side and rear of the property. Transport is provided to residents so as they can access community based amenities, go to clubs, various day services and on holiday breaks. Systems are in place to ensure the health and wellbeing of the residents is provided for, and as required access to a GP and a range of other allied healthcare professionals form part of the service provided. The centre is staffed on a 24/7 basis and is managed by a qualified person in charge, who operates as a clinical nurse manager II (CNM II). She is supported in her role by an area coordinator and a team of qualified nursing professionals and healthcare assistants.

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 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 5 December 2022	09:15hrs to 15:25hrs	Stevan Orme	Lead

What residents told us and what inspectors observed

This centre is run by the Health Service Executive (HSE) in Community Healthcare Organisation Area 1 (CHO1). Due to concerns about the management of safeguarding concerns and overall governance and oversight of HSE centres in Co. Donegal, the Chief Inspector undertook a review of all HSE centres in that county, including a targeted inspection programme which took place over two weeks in January 2022 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection) and regulation 23 (Governance and management). The overview report of this review has been published on the HIQA website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors are now completing a programme of inspections to verify whether these actions have been implemented as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Donegal.

At the time of the inspection the provider had implemented a number of actions to strengthen governance and management arrangements (regulation 23) as well as actions relating to positive behaviour support (regulation 7) and protection (regulation 8) which had positive impacts on the care and support provided to residents and well as the day-to-day operations of the centre. However improvements were still required in relation to the design and layout of the centre as well as staff training and arrangements to ensure residents were safeguarded from all types of harm, these will be described later in this report.

On the day of inspection, the Person in Charge (PIC) was absent, and therefore the inspection was facilitated by the centre's Clinical Nurse Manager (CNM2). The inspector had the opportunity to meet all nine residents who lived at the centre and spoke with them about the care and support they received at the centre.

Residents spoke repeatedly about how they were looking forward to moving to three new designated centres in the local area, with one resident expressing frustration that this had not occurred to date. Residents further showed their eagerness to move to their future homes, but telling the inspector about items such as pictures and bed linen they had been purchasing for their planned move. Staff told the inspector that although residents had been unable to move into their new homes, they were supported to regularly visit them, take over personal possessions and have meals at the centres.

The residents' desire to move to their new home was also reinforced by the inspector’s observations on the day as due to the residents’ needs and the space available at the centre impacted on residents’ day-to-day life. For example, the inspector observed the limited space available when residents, their wheelchairs and supporting staff were in the centre’s communal lounge. Also two residents were

accessing the centre's dining room at the start of the inspection, and again due to limited space, staff told the inspector that residents had to have their meals at different times and could not all eat together if their choose too.

The inspector observed that residents had personalised their bedrooms at the centre with ornaments, pictures, family photographs and other personal items. However, eight of the nine residents continued to share a bedroom with personal privacy only being maintained through the installation of privacy curtains.

Although residents were frustrated by delays in moving to their new homes, they appeared comfortable with all care and supported provided by staff at the centre. Throughout the inspection, staff ensured that residents were offered choice in regards activities undertaken, with some residents opting to having their hair curled and nails painted in the morning, while others went on the centre's transport to a local place of interest and for a meal out. The inspector in the afternoon also observed residents preparing to to visit the new homes.

Residents chatted to the inspector in the lounge about activities they enjoyed like visiting family and listening to music. One resident told the inspector they were a good singer and their love of music and favourite singer; Elvis Presley.

In summary, the inspector found that care and support provided meet the needs of residents, however improvement continued to be required to ensure the centre's premises met residents' needs, supported their right to privacy and provided adequate personal space, which will be described later in the report.

Capacity and capability

In addition, to reviewing the actions taken by the registered provider in response to the targeted inspection programme in January 2022, the inspection also reviewed actions undertaken by the provider in response to the findings of the centre's previous inspection in January 2021. The inspector found that governance and management arrangements ensured that residents' needs were met, however delays in transitioning to three newly registered purpose built centres in the local area continued to impact on residents' lives.

The person in charge was absent on the day of inspection and therefore the inspection was facilitated by a Clinical Nurse Manager (CMN2). Through discussion and review of available documentation it was apparent that governance and management arrangements at the centre had been enhanced since the last inspection in January 2022. The provider had reviewed and subsequently introduced a new audit schedule at the centre which gave increased oversight of all aspects of care and practice. Audits were completed by delegated nursing staff and the findings addressed or escalated to the person in charge for inclusion in the centre's Quality Improvement Plan (QIP) which was submitted to senior management monthly. The QIP highlighted all areas for improvement at the centre with clear

timeframes and person's responsible to ensure its achievement, with the inspector noting that the transition to the new designated centres was the main focus for the centre presently.

Staff members spoke about the approachable nature of the centre's management team and how they could raise concerns or seek clarity on issues when they occurred. Staff members attended regular team meetings which occurred every six to eight weeks, and told the inspector that they were able to add items for discussion to the proposed agenda. In addition, newly recruited staff spoke about how they were inducted into the centre, which included one-to-one induction sessions with managers on residents' needs and the day-to-day operation of the centre as well as shadowing experienced staff.

The CNM2 also spoke about further governance changes implemented by the provider following the outcome of HIQA's targeted inspection programme in January 2022 across designated centres in Co. Donegal. They spoke about and provided meeting minutes from a range of new governance meeting that either they or the PIC attended. New governance meetings were specific to human rights, quality improvement, safeguarding reviews as well as bringing together all persons in charge from across Co. Donegal. The CNM2 told the inspector that the Donegal PIC meetings had a positive impact, giving opportunities to receive updates on policy and practice changes , raise concerns and share learning from across all of the provider's designated centres.

Residents were supported by a team of both nurses and health care workers, with a minimum of one nurse and three to four health care workers on duty during the day. At night-time, residents were supported by a waking night team of one nurse and one health care worker. A review of documentation and discussions with staff members gave assurances that current staffing arrangements ensured that residents' assessed needs were meet and they were supported to access a range of activities both at the centre and in the local community.

Access to regular training ensured that staff knowledge was up-to-date and reflected current best practice in health and social care. However, although staff had access to this resource, further improvements were required to ensure all staff successfully completed training in areas such as 'Sexuality Awareness in Supported Settings' and infection, prevention and control.

In summary, the inspector found improvements had occurred following the last inspection in January 2022, which had further strengthened the governance and management arrangements at the centre and had led to improvements for residents. However, further action was required to ensure staff completed up-to-date refresher training.

Regulation 15: Staffing

Staffing arrangements at the centre ensured that residents' assessed needs were

met, and that an appropriate number of qualified staff were available at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a range of training including areas specific to the needs of residents. However, not all staff had completed training in 'sexuality awareness in supported settings' and the provider's online training in infection, prevention and control.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme in January 2022, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. At the time of the inspection all 11 actions had been completed.

The centre had a clear governance structure in place which ensured the effective oversight of the centre. Following the targeted safeguarding inspection programme in January 2022, the provider had further enhanced governance at the centre through a review of audit systems and the development of a range of governance meetings attended by either the PIC or CNM2. Governance meetings examined areas such as the effectiveness of safeguarding plans, quality improvement initiatives and policy development. The CNM2 spoke about how these meetings were beneficial both in order to update their knowledge and to provide an opportunity for improvement through shared learning with their peers.

However, although governance and management had improved at the centre, this had not ensured that residents' assessed needs were met through access to suitable premises as referenced in regulation 17of the inspection report.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of accident and incident reporting at the centre reflected that the provider had ensured that all notifiable events were reported to the Chief inspector in

accordance with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider's compliant management arrangements ensured that complaints were recorded and investigated in line with the provider's policies. In addition, records summarised actions taken in response to received complaints and whether or not the complainant was satisfied with the subsequent outcome. Where complainants were not satisfied, the provider's policy gave direction on how to make an appeal.

Judgment: Compliant

Quality and safety

The care and support provided at Dungloe Services 2 ensured that residents' assessed needs were met and they were supported to achieve personal goals. However, delays in addressing issues relating to the design and layout of the premises impacted on accessibility and residents' privacy.

As part of the inspection, the inspector reviewed progress by the provider in achieving compliance with regulation 17 (premises). Previous inspections had highlighted the unsuitable design and layout of the centre to meet residents' needs, especially as a significant number of residents were wheelchairs users. As on previous inspections, the inspector observed that there was insufficient space in both the lounge and dining room area for the number of residents living at the centre. This was especially noted in relation to the dining room, where residents had to eat their meals at different times due to the lack of space. Furthermore, the majority of residents continued to share bedrooms, with only an installed curtain to ensure their privacy. The inspector also observed that due to inadequate storage facilities, bathrooms were also used to store personal care supplies as well as shower chairs and other aids. Furthermore, the inspector observed wear and tear to the premises associated with wheelchair use such as damage to door frames.

The inspector also visited the isolation unit as part of the inspection. The unit was part of a day service in the local area and was only used in the event of an outbreak of COVID-19. At the time of the inspection, there were no reported outbreaks of infectious diseases and therefore the unit was not in use. However, a walk around found that the premises was in a good state of repair and in the event of use could be fully separated from the day service and be self-contained to prevent the spread of infection.

Residents' personal plans were comprehensive, providing guidance to staff on how to support all aspects of residents' needs. Nursing interventions based on resident's needs were reviewed every three months by a named nurse which ensured they were up-to-date and reflected any changes in support. Annually, personal plans were subject to a review attended by the resident, their family, centre staff and associated multi-disciplinary professionals, with any subsequent recommendations being incorporated into the person plan to ensure its ongoing effectiveness.

Where residents required supports with behaviours of concern, this was also included in their personal plan along with a detailed 'Behaviour Support Plan'. The plan was subject to a regular review by a senor clinical psychologist to ensure it was up-to-date and met the resident's needs. Reviewed plans clearly described the behaviour of concern and agreed proactive and reactive supports to be used by staff. Where residents required medication as part of their support, clear protocols were in place to ensure these were administered only when all other methods had been tried. In addition, staff knowledge in this areas was supported through access to regular positive behaviour management training.

Risk management arrangements at the centre ensured that all known risks were identified and measures put in place to mitigate against their impact. Risk measures were subject to regular review which ensured their effectiveness and where required were escalated to senior management. The inspector noted that risks currently escalated related to the suitability of the premises and the centre's kitchen and rear car parking area. Records clearly showed actions to support the residents to transition to the aforementioned three new designated centres, as well as planned to address the kitchen are area parking area folloiwng residents' transition in 2023.

Safeguarding arrangements at the centre also protected residents from the risk of harm. Staff were knowledgeable on how to report a safeguarding concern and had access to a designated safeguarding officer when required. There were no current safeguarding concerns at the centre, and a review of records relating to previous concerns showed that these had been managed in line with the provider's policy and ensured residents were protected from further harm.

The provider also ensured that staff knowledge in this area was reinforced through access to regular training. However, not all staff had completed training in 'sexuality awareness in supported settings' which was part of the provider's response to the findings of the targeted safeguarding inspection programme in January 2022. In addition, the provider had also not yet implemented its 'Provision of Safe Wi-Fi Usage' policy as committed to in its response to the targeted inspection programme in January 2022. However, in the absence of the aforementioned policy, staff had developed a risk assessment on how to support residents when accessing the internet and ensure their safety.

In conclusion, care and support provided to residents ensured their needs were meet, although this would be further enhanced through the provider putting measures in place to address the ongoing issues relating to the design and layout of the centre. In addition, further actions was required to ensure measures were in

place to protect residents from harm.

Regulation 13: General welfare and development

Residents were supported to access their local community in accordance with their assessed needs, preferences and personal goals for the year.

Judgment: Compliant

Regulation 17: Premises

The provider had not ensured that the design and layout of the premises meet the assessed needs of residents. Although alternative accommodation had been identified, due to the postponed transition of residents to three new designated centres in the local area, residents continued to live in a premises which:

- 8 out of the 9 residents had shared bedrooms where privacy was only maintained through the installation of a privacy curtain

- Due to residents using wheelchairs , the communal lounge did not provide adequate space for all residents

- The dining room due to its size prevented residents for eating meals at the same time or when they chose

- The centre's kitchen did not meet the provider's health and safety standards

- Flooring throughout the centre was damaged

- Door frames throughout the centre were damaged due to residents' wheelchairs

- In adequate storage facilities were available at the centre for aids and appliances as well as personal care supplies

Judgment: Not compliant

Regulation 26: Risk management procedures

Risk management arrangements at the centre were comprehensive, clearly identified risks and measures to mitigate its effect. Staff were knowledgeable on risk control measures in place, and where risks could not be effectively managed these

were escalated to senior management such as the appropriateness of the centre's kitchen and premises.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Comprehenisve personal plans were available to staff to ensure they meet residents' assessed needs. Plans were subject to an annual review , with subsequent recommendations incorporated to ensure their effectiveness.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme and previous inspection of the centre in March 2022, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements relating to positive behavioural support at the centre.

At the time of the inspection, the inspector found that all seven actions had been implemented. Residents had access to a range of multi-disciplinary supports such as a senior clinical psychologists who developed and regularly reviewed behaviour support plans to ensure their effectiveness. In addition,staff had access to positive behaviour training which ensured their knowledge and practice was up-to-date and meet residents' needs.

Induction arrangements were also in place to ensure that all staff including temporary workers had sufficient knowledge of residents' needs including behavioural supports to ensure the consistency of care provided to residents.

Judgment: Compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements relating to protection at the centre. At the time of inspection, the provider had commenced and completed 11 of the actions.

The provider had further enhanced its arrangements for the review and support of

safeguarding plans to ensure their effectiveness in meeting residents' needs and mitigating risk. Staff had also undertaken safeguarding training as part of the provider's mandatory training programme , although as referenced in regulation 16 (Training and Staff development) , not all staff had completed required 'sexuality awareness in supported services' training at the time of the inspection. In addition, the provider had not completed the development of its proposed policy on safe Wi-Fi usage to ensure residents were protected from all forms of possible risk, although as an interim measure the centre's management team had developed a risk assessment on Internet access to protect residents.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Dungloe Services 2 OSV-0002506

Inspection ID: MON-0032881

Date of inspection: 05/12/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with regulation 16(1)(a) the following actions have been taken: • A Personal Training Needs Analysis has been provided to all staff and a request issued for all online training to be completed by 31/12/22. • Sexuality Awareness in Supported Settings Training scheduled for 6 staff in 2023. Completion Date: 28/02/2023	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure compliance with regulation 23(1)(c) the following actions have been taken: • Donegal Disability Management continue the progress supporting residents in Dungloe Services 2 to transition to 3 purpose built facilities within the local area. Completion Date: 31/03/2023.	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance with regulation 17 the following actions have been taken:

• Donegal Disability Management continue the progress supporting residents in Dungloe Services 2 to transition to 3 purpose built facilities within the local area. Completion Date: 31/03/2023.

• 17(1)(b) All outstanding maintenance work has been escalated to maintenance and works will commence Q1 2023

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance with regulation 8(2) the following has actions have been taken:

• Donegal Disability Service is currently developing a policy on the provision of safe Wifi usage in conjunction with the Digital Health Lead, Health and Social Care Professionals and in consultation with other care group services. Completion date: 31/12/2022

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 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	28/02/2023
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	31/03/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Not Compliant	Orange	31/03/2023

	state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly 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.	Not Compliant	Orange	31/12/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022