Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Dreenan Ard Greine Court
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	27 September 2022 and 28 September 2022
Centre ID:	OSV-0005490
Fieldwork ID:	MON-0036791

About the designated centre

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

Dreenan provides full-time residential care and support for up to six adults with an intellectual disability. Dreenan comprises of a six bedroom bungalow and residents have access to communal facilities at the centre which include two sitting rooms, a dining room, a kitchenette, a laundry room and bathroom facilities and each resident has their own bedroom. The centre is located within a campus setting which contains six other designated centres operated by the provider. It is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and cafes. Residents are supported by a staff team of both nurses and health care assistants. During the day, residents are supported with their assessed needs by four staff members with one nurse being on duty at all times. At night-time, residents are supported by two staff, a nurse and health care assistant.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 September 2022	14:15hrs to 18:30hrs	Angela McCormack	Lead
Wednesday 28 September 2022	10:15hrs to 15:30hrs	Angela McCormack	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 have now commenced 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 the governance and management. In addition, a number of actions relating to positive behaviour support (regulation 7) and protection (regulation 8) had been completed or were in progress. These will be discussed in the other sections of the report.

There were four residents living in Dreenan at the time of inspection, with two vacancies. The inspector was informed that there were no plans for anyone to move into the centre at this time. The inspector was informed about plans that were in progress for one resident to move to a more suitable home in the future, in line with their wishes to live with others with whom they have something in common.

The inspector got the opportunity to meet briefly with three residents over the course of the inspection. Residents interacted with the inspector on their own terms and with the support of staff and were observed to be relaxed in their home. One resident was attending a healthcare appointment on the first afternoon of the inspection, and attended a day service the following day. They were reported to be resting in their bedroom at other times, therefore the inspector did not get an opportunity to meet with them on this inspection.

Observations throughout the inspection indicated that residents appeared relaxed in their environment. Residents greeted the inspector on their own terms and through their communication methods, such as smiling, gestures and vocalisations. One resident was observed relaxing in the sitting-room listening to relaxing music, with an aromatherapy scent diffuser on, which created a relaxing and warm space. One resident had spent some time in the 'snoozelum' room on the campus, and the inspector met them briefly on their return. Some residents were reported to be

going to another county in the afternoon to visit an amenity there.

Through a review of documentation, photographs and discussions with staff and the management team, it was evident that residents enjoyed a variety of activities and outings in line with their wishes, stages of life and developmental needs. Some residents had gone on a two night break over the Summer, which they were reported to have really enjoyed. Photographs from this holiday indicated residents' enjoyment of this also. Other activities that residents enjoyed included; day trips to tourist amenities, attending country music concerts, going to the cinema, going on shopping trips and having meals out. Residents also enjoyed reflexology, massages, getting take-aways, gardening, baking and using sensory room in their home or at a location on the campus. One resident attended an external day service and had choice about whether they attended or not. Another resident was part of a community group for older people, which they attended one day per week. Residents could also access particular outings and programmes in a nearby hub run by the provider, as and when suitable activities were planned. Residents were reported to have good communication and contact with their families, and visitors were welcome to Dreenan. There was an area in the house to receive visitors also, to allow space for privacy.

Staff were observed to be caring and respectful in their interactions with residents and responsive to their needs. Residents were supported by staff in line with their assessed needs and staffing requirements throughout the inspection. However, at times the regular staff working in Dreenan were moved to respond to staffing issues in other centres and this impacted the continuity of care for residents in Dreenan. On the days of inspection, one regular staff nurse was relocated to another designated centre to provide support. This will be discussed in the next section of the report.

Staff members spoken with described about what life was like in the centre for residents. Residents were dependent on staff for most of their care needs. Consistent and familiar staff were noted to be important in ensuring residents' support needs were met. Staff appeared knowledgeable about residents' specific care needs and about how to support them with health issues and anxiety behaviours. There were some incompatibility issues between residents living in the centre, and this was evident through a review of incidents that occurred and through a review of various documentation, where this was acknowledged also. One resident had requested to move to a different home with peers that they would be compatible with, and a review of this was noted to be in progress. The inspector was informed that this would be further reviewed at a meeting scheduled for later in the week. The resident raised this a few times with the staff team, and this had been logged as a complaint each time. It was noted on the open complaint that the resident had been updated with the progress to date on this issue.

The house appeared homely, clean and spacious for the needs and numbers of residents. There were framed photographs on display throughout the home, which included residents and their friends. There was a staff photo roster on display on the residents' notice board in the hallway. There were notice boards with information for

residents including easy-to-read information about various topics.

The back garden area was spacious and well maintained. It contained garden furniture, a swing bench, a basketball hoop and some garden ornaments. The front of the house was decorated with a variety of garden ornaments and potted plants and flowers. The back garden was accessible through double doors leading from three communal rooms.

The house was spacious for four residents. Each resident had their own bedroom with some bedrooms having en-suite facilities. Bedrooms that the inspector observed were found to be clean, personalised and comfortable. Residents had DVD players, music players and personal effects in their rooms. The communal bathrooms were large with level access showers and a Jacuzzi bath also. There was a large living room which was decorated with a feature wall and soft furnishings and contained comfortable furniture and a television. There was a separate utility area which stored laundry equipment, and which was accessible through the hallway.

The kitchen area in the house was small and not fully accessible for wheelchair users. There were plans in place to alter this, and this had been an action on previous inspections by the Health Information and Quality Authority (HIQA). This was due to be completed by mid 2023. The kitchenette contained some cooking equipment and a fridge to store food items. The kitchen cupboards and fridge were observed to be stocked with fresh food and frozen food items and there were treat boxes for sweet treats if residents chose this. One resident was supported to keep their treats in their bedroom and a small fridge was in place for this. The dining room had two sets of tables and chairs, a dresser and notice board which contained meal choices, the shopping list and the meal plan for the day. Residents' two main meals were delivered from a centralised kitchen on the campus and the inspector was shown the menu options for each day where residents' had the choice of two options for each meal, which they chose the day before. The inspector was informed that if residents' changed their minds that this would be facilitated, and that one resident was often supported to ring the kitchen to change their request.

There were some safeguarding concerns and incompatibilities between residents living in Dreenan. Environmental measures, staffing numbers and the implementation of care plans to support residents and guide staff helped to reduce and minimise potential safeguarding risks. However, it was recognised in various documentation and care plans that the safeguarding risks will remain until such a time that some residents did not live together. This will be discussed further in the next sections of the report.

In general, the inspector found that the service strived to provide a good quality and person-centred service to residents. However, improvements in staffing arrangements and protection would further enhance the safety and quality of care provided. The following sections of the report outline the governance and management and how this impacts on the quality and safety of care provided to residents.

Capacity and capability

This inspection was a follow up inspection to review actions required arising from an inspection by the Health Information and Quality Authority (HIQA) in February 2022. Actions included on the compliance plan from the overview report for CHO1, as mentioned previously, were also reviewed. In addition, the provider was required to submit monthly updates about a management improvement plan to HIQA since April 2021, and some of these actions were also reviewed.

Overall, improvements were found in the governance and management and oversight arrangements in Dreenan. However, further improvements were required to ensure regulatory compliance. These included areas such as staffing, staff training, premises, the submission of notifications to the Chief Inspector and in ensuring the protection of residents. These will be discussed throughout the report.

The management structure consisted of a person in charge who had responsibility for one other designated centre which was also located on the campus. They reported to the director of nursing (DON). A clinical nurse manager 1 (CNM1) had been appointed as part of the management improvement plan from April 2021 to support the person in charge with the operational management of the centre. The person in charge was on leave at the time of inspection; however the CNM1 and DON were available. The CNM1 appeared knowledgeable about the needs of residents and the running of the centre, and they supported the person in charge in areas such as auditing, oversight of operations and staffing.

Staffing arrangements were reviewed as part of the inspection. The staffing skill mix included nursing staff and healthcare assistants. A review of the roster showed that in general there was the numbers of staff working to meet the needs of residents. Some agency staff were used to fill staffing gaps, such as planned leave, sick leave etc however this was kept to a minimum and in general there was cohort of regular agency staff used. However, the continuity of care of residents was impacted at times due to the need for Dreenan staff nurses to relocate to support nursing vacancies in other designated centres. For example, on the two days of inspection, one of the staff nurses on duty was relocated to another centre, which meant that they were back filled by agency staff who were not part of the dedicated agency staff used. A review of the roster indicated that over ten weeks, a staff nurse was moved out of Dreenan 14 times, and on one occasion, the numbers of staff supporting residents were reduced from four staff to three as a result. The local management team had assessed this risk and reported that they had recently escalated it to senior managers. This required review by the provider to ensure that residents in Dreenan were not impacted by staffing deficits in other locations.

There was a range of mandatory training programmes identified by the provider for staff working in the centre. Staff training information was recorded on a staff training matrix which was reported to be the centre's training needs analysis also. This included information about when staff had completed training and if they were due training or refreshers. There were two matrices maintained; one for permanent

staff and one for agency staff. However, it was found that one agency staff who was working on the day of inspection had not been included on this. Therefore the ongoing oversight of staff training to ensure that residents were appropriately and safely supported required review.

A sample of training records was reviewed and in general demonstrated that staff members had competed the mandatory and refresher training as required. However, some training programmes were outstanding and there were plans in place to address this. For example, one staff required refresher manual handling training and two staff required fire training with dates set for the coming weeks. In addition, staff required specific training which was recommended in one resident's occupational therapy report from 2021 and this had not yet been completed. While dates had now been set for this training, this had been an action identified in the February 2022 inspection, and was due to be completed by May 2022. This required improvements to ensure staff had access to appropriate training to support residents' needs, as recommended.

The provider had implemented a number of governance meetings as part of their action plan from the overview report to strengthen the oversight and management systems. A sample of meeting minutes were reviewed on the inspection including; the local governance meetings (held bi-monthly), county level person in charge meetings (held fortnightly), and quality, risk and patient safety group (held quarterly). The person in charge meeting minutes reviewed demonstrated that shared learning occurred. However, it was found that the local team meetings did not include all staff members. The inspector was informed that team meetings included participation of a 'line' of staff on alternating meetings, as it could be difficult to get all staff to attend the same meeting. A sign off sheet was to be used for staff who were not in attendance to sign that they had read the minutes, however this was not consistently used. In addition, a review of the four meetings held so far in 2022 indicated that the same 'line' of staff attended three of these meetings, meaning that a number of staff did not have the opportunity to attend the local governance meetings, with some staff not having attended any meeting so far in 2022. This required improvements to ensure that all staff had the opportunity to raise any concerns about the quality of service, and to also ensure that the provider's identified action to improve governance and management was met. The local management team spoke about reviewing this and developing a schedule to ensure all staff had the opportunity to attend staff meetings.

The centre had a quality improvement plan which contained all actions arising from the provider audits, HIQA inspections and from a person in charge self-assessment tool used to monitor compliance with regulations. There was also a suite of audits completed in the centre for ongoing monitoring by the local management team and the provider. As part of the provider's actions from the overview report, a new schedule of audits had recently been implemented in the centre. This included audits in areas such as; finances, medication, health and safety, fire safety, infection prevention and control (IPC), restrictive practices, safeguarding and personal plans and which were identified to be completed at set intervals during the year. A staff awareness audit tool was in use for assessing staff's knowledge about safeguarding. However, on discussion with the CNM1, it was not clear how the local management

team could monitor that the assessed staff's knowledge and competency about safeguarding was effective, as the questions included a check box to tick if a 'satisfactory response' was received, all of which were ticked as 'yes', with no comment to confirm this. Also the audit tool was completed by a staff member on another colleague, and there was no system established to monitor this by the local management team to review if the questions asked did in fact elicit a 'satisfactory' response or not. This required review to ensure the effectiveness of this audit tool.

The provider ensured that unannounced six monthly audits were completed. A provider nominee visited the centre on the second day of inspection to carry out a provider audit. There was one completed in June 2022, which identified a number of areas for improvement. However, the oversight and time-frame for some actions required review to ensure that they were achieved within the time-frame set out. For example; the provider audit included consultation with residents and their families, and an issue raised by one family was actioned to be completed by the end of July, however it was not clear that this action had been fully achieved.

The complaints process and record of complaints were reviewed. It was found that complaints were taken seriously and residents were supported to raise complaints in the centre, and were kept informed about the progress of their complaint. In addition, a complaint raised on behalf of some residents by their advocates were being followed up by senior managers and this was noted to be in progress at the time of inspection.

A review of incidents and practices in the centre indicated that the person in charge had submitted most of the notifications as required in the regulations for the Chief Inspector of Social Services. However, not all had been submitted. This included one suspected safeguarding allegation that was recorded on an incident report form. The inspector was informed that this was an oversight by the person in charge due to the fact that a similar incident had occurred a few days previously for which a notification had been submitted. Improvements were required to ensure that all notifications were submitted in line with the regulations.

While audits and reviews of incidents were being completed regularly, they required improvements as they failed to pick up some actions for improvement as found on inspection. This included the omission to send one notification about a possible safeguarding incident to the Chief Inspector and in identifying some issues with the premises.

Overall, the inspector found the governance and management arrangements were good. However, improvements were required in staffing, training, management of staff meetings and in ensuring that audits were effective in identifying areas for improvement and non-compliance.

Regulation 15: Staffing

The staffing arrangements required improvements to ensure continuity of care to

residents. This related to an arrangement whereby at times staff nurses working in Dreenan were required to cover nursing duties in other designated centres on the campus, which meant that they were back filled by agency staff who were not part of the main cohort of regular staff at times

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff matrix did not include all the agency staff who worked in the centre, which meant that assurances that all staff supporting residents had the required training could not be verified. For example, one staff working on the day of inspection was not included on the training matrix. Some refresher training was outstanding; such as manual handling refresher training and fire safety for some staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO1. At the time of the inspection the inspector was informed that all 10 meetings and committees had commenced and the new audit schedule had been implemented in August. The inspector reviewed evidence of five actions on this inspection including the new audit system, a review of the minutes from the county person in charge meetings, the quality, safety and service improvement meetings, the centre governance meetings and the inspector was informed about the person in charge and DON meetings that occurred bi-monthly. There was evidence found in these meetings of shared learning between centres and a review of incidents and issues occurring in specific centres, including staff training needs and staffing issues.

However, improvements were required in Dreenan in the following areas:

- To ensure that all staff had opportunities to attend the centre governance meetings in line with the provider's actions from the overview report
- To ensure that audits effectively captured and monitored what they were designed to audit. For example, the safeguarding awareness audit required review to ensure it's effectiveness and the environmental health and safety audits required improvements to ensure issues with premises were identified.
- To ensure that time-frames assigned to achieve actions were realistic and

kept under review for completion within the time-frames allocated.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

While most notifications that were required to be submitted to the Chief Inspector had been done, it was found that one safeguarding concern had not been notified as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were recorded and kept under review. Where residents raised dissatisfaction with aspects of the service, these were taken seriously and the complaints procedure implemented and updates given to residents. Complaints made on behalf of residents by advocates were being followed up by senior managers.

Judgment: Compliant

Quality and safety

Overall the inspector found that residents were supported with their needs and were provided with care that promoted their health and safety. However, some improvements were required in addressing the compatibility issues which could impact on residents' wellbeing and protection, and in some aspects of the premises. These would further enhance the quality of care and safety provided.

Residents had comprehensive assessments of needs completed of their health, personal and social care needs. A range of care and support plans were developed where needs had been assessed. Since the previous inspection by HIQA in February 2022, one resident now had a personal and social care goal of moving out of Dreenan included on their personal plan and this was reported to be in progress and prioritised by the provider.

Resident annual review meetings and person centred meetings occurred, which included consultation with residents and their family representatives where relevant. Residents had person- centred plans in place were personal goals for the future

were identified, and which contained photos of goals achieved. Some of these goals included; going on holidays, going to country music concerts and visiting tourist attractions in Ireland. Goals were found to be kept under review for progress, and the photos in place in the easy-to-read plan indicated residents' enjoyment of the various activities that they engaged in.

Residents were supported to achieve the best possible health. There were various care and support plans in place to guide staff in how best to support residents with their individual healthcare needs. There were also comprehensive personal and intimate care plans in place to guide staff on supports required in this area. Residents were facilitated to access allied healthcare professionals as required and recommended and one resident was under ongoing review with a multidisciplinary team (MDT), to ensure appropriate supports were in place to optimise health. Residents also had access to MDT supports such as psychology services and behaviour support specialist as required. Training was outstanding for staff to support with one resident's occupational therapy recommendations and this was scheduled for the end of the month. This outstanding action is covered under regulation 16 on staff training and development.

Residents that required supports with behaviours of concern had behaviour support plans in place, which had recently been reviewed with the relevant members of the MDT. A plan reviewed was found to be comprehensive and clearly outlined triggers to behaviours and specific supports and interventions to be put in place. In addition, there was a crisis management plan, to support the BSP, which had recently been reviewed and outlined when, and why, a restrictive practice should be utilised to minimise risks associated with one resident's behaviours. This was reviewed following incidents that occurred previously. It was noted that this was discussed with the resident and that they had signed that they agreed with the measures to reduce the identified risks. A sample of other restrictive practices reviewed found that they were kept under review by the person in charge and included in an auditing schedule. Restrictive practices had been risk assessed also, and included a description of the risks associated with not using a particular intervention. These actions demonstrated good monitoring of restrictive practices to ensure that they were proportionate to the risks identified and to ensure the safety of all.

Safeguarding of residents was promoted through staff training, reviews of incidents that occurred and the implementation of safeguarding plans where required. In addition, the use of the environment and staffing numbers helped to support the protection of residents. Staff spoken with were aware of potential safeguarding risks and about how to minimise the risks. However, compatibility issues remained in Dreenan. A number of documents in place outlined that safeguarding risks would remain as long as some residents remained living together. One resident's' behaviour support plan included the possible need to move other residents within the house to ensure their safety at times of high risk behaviours. The inspector was informed about discussions and plans in progress to address the compatibility concerns and one resident had been supported to access an independent advocacy service in relation to their wishes for future living arrangements. However, until this issue of incompatibility was resolved, a risk of safeguarding incidents occurring

remained.

The management of risk was found to be good overall. There was a policy and procedure for risk management in place and a risk register developed for any identified centre risks, In addition, risks identified for residents had risk assessments in place. These were found to be kept under regular review by the local management team and updated as required. Where risks were required to be escalated to senior management, this had been done recently. A small number of the risk ratings assigned to some risk assessments required review and this was addressed on the day by the CNM1.

The premises was spacious to meet the needs of four residents. Each resident had their own bedrooms which were personalised and had televisions and music players for recreation. In addition, the bedrooms provided suitable space for the storage of personal possessions. The communal areas were spacious and there were a number of communal rooms to promote space for residents to relax in small numbers or alone. The kitchenette was small and did not fully support accessibility for wheelchair users. An action to address this remained in progress. In addition, an issue found in the previous HIQA inspection relating to damage to the door frame had not been addressed. A walkaround of the premises also found that there was a damp patch on the ceiling in one of the communal sitting rooms, which appeared to be coming from a sky light window and leading to a light fixture on the ceiling. The CNM1 reported this to the maintenance department immediately when it was brought to their attention. These issues with the premises required completion to ensure that the premises met all the requirements with the regulations.

In summary, while the service strived to ensure residents' safety and wellbeing due to compatibility issues, there remained a risk to some residents' wellbeing and safety. In addition, some aspects of the premises required further review and ensuring the completion of actions.

Regulation 17: Premises

The following issues related to the premises required review and completion;

- a review of the damaged door frame surrounding the kitchen door
- a review of possible leak in one sitting-room leading to a light fixture
- the full completion of the works planned to ensure accessibility to the kitchen

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were good processes and arrangements in place for risk management;

including the identification, assessment, documentation and ongoing review of risks.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Comprehensive assessments of needs were completed on resident's health, personal and social care needs and personal care plans developed as appropriate. Resident annual review meetings occurred, which included residents and their represenatatives.

Judgment: Compliant

Regulation 6: Health care

Residents were supported with health related needs and care plans were in place to ensure and promote optimal health. Residents were support to access allied healthcare professionals, health scans and consultants as recommended.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, 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. One action related to the approval of MDT supports, three actions related to staff training and ensuring staff have knowledge about behaviour support plans and three actions related to the induction of new staff. Six actions were reviewed by the inspector during this inspection and found to be completed. This included the training needs analysis, the review of training needs at governance meetings and the induction pack and checklist for new staff for the centre. While the action relating to the appointment by the provider of additional MDT supports was not fully reviewed at this time, it was found that residents in Dreenan had access to behavioural specialists and psychology supports for behavioural needs, as required.

Positive behaviour support was found to be managed and monitored well in Dreenan. Staff were trained in the behaviour management training. Residents who required supports with behaviours of concern had comprehensive plans in place which were kept under review. Restrictive practices had been assessed and were

kept under ongoing review.

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. The inspector reviewed eleven actions at this time and ten were found to be completed, with one in progress. The DON showed the inspector the safeguarding tracker that was in place and discussed how this was used to track all open safeguarding cases in the network area under their remit. The inspector was informed that the person in charge had undertaken the two training modules that were outlined in the overview report as required. Staff had completed the training on 'Sexuality Awareness in Supported settings' (SASS), with one agency staff due to complete it and this was being scheduled at the time of inspection. The training needs analysis of the centre was in place and training needs found to be reviewed at governance meetings, and the revised audit scheduled included audits on safeguarding had been implemented. The development of a 'Policy on the provision of safe wi-fi usage' had not yet been achieved and was reported to be in progress.

In Dreenan there remained incompatibility issues which impacted on residents' ongoing protection from possible safeguarding incidents. There had been a number of incidents that occurred since the last inspection between two residents and a safeguarding plan was in place. While the inspector was informed about actions in progress to address the incompatibility, this risk remained until such a time that some residents did not live together.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While the use of a centralised kitchen on the campus for residents' main meals remained in place, there was a system for residents to make choices about what meals they liked, and if they changed their mind, this was supported with alternatives available.

Residents' rights were promoted in the centre through access to advocacy services, consultation about choices and through regular residents' meetings where information was shared and choices about their lives were discussed. The use of a technological device was in place for some residents to support them to make

various choices in their lives.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dreenan Ard Greine Court OSV-0005490

Inspection ID: MON-0036791

Date of inspection: 27/09/2022 and 28/09/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The Person in Charge will ensure that the centres roster is reviewed daily to ensure it is reflective of the staff on duty daily – Completion date: 30/09/2022 2. The Person in Charge in conjunction with the Director of Nursing will complete a full review of staffing within the centre - Date for completion 14/11/22 3. The Person in Charge will ensure that there are regular agency staff assigned to the centre to ensure consistency for all residents – Completion date 31/10/22	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The Person in charge has commenced a further review of the training matrix to ensure that training requirements for dedicated agency staff are included – Date for completion 30/11/22 2. The Person in charge will schedule all staff for refresher training with emphasis on manual handling and fire training – Date for completion: 15/12/22 3. The person in charge will continue to monitor the training matrix on a monthly basis and schedule training as required - Completed 30/10/22	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Person in Charge has reviewed the schedule in place for governance meetings to ensure that the full staff team have the opportunity to attend all meetings Completed 31/10/22
2. The person in charge in liaison with the director of nursing have reviewed the audits with particular reference to the safeguarding and health and safety audit to ensure that they are completed effectively. Completed 31/10/22
3. The Person in charge will ensure that all actions arising from the audits are included and monitored on the centres Quality improvement plan. Completed 31/10/22
4. The person in charge will continue to monitor the centre quality improvement plan in a weekly basis and the director of nursing will monitor monthly. Completed 31/10/22
5. The person in charge in liaison with the director of nursing will review the timeframe for actions to ensure that they are realistic and achieved within the required timeframes. Completed 31/10/22

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. The Person in Charge has retrospectively ensured that all notifications in relation to safeguarding incidents were submitted to the regulator. Completed 04/11/22
2. The Person in Charge will ensure that all notifications are submitted to the regulator within the required timeframes as per the regulations – Completed 31/10/22

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1) The Person in Charge has ensured that the damaged door fame surrounding the kitchen door has been reviewed and subsequently replaced – Completed: 29/09/2022
2) The PIC has ensured that the leak in the bottom sitting room has been reviewed by the maintenance department and a new window has been ordered are will be fitted when it is available – Completion date: 29/09/2022
3) The HSE has engaged an architect and plans have been developed plans to reconfigure the layout of the kitchenette within the centre. The commencement of works

has been delayed however works will be completed by the end of quarter 2 2023. Date for completion: 30/06/2023

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The provider is currently developing a Safe Wifi Usage Policy for the Service. A request for an extension for this specific action has been sought by the Head of Service Disability Services on the overall Donegal Disability Services Compliance plan. – Date for completion 31/12/2022
2. The Person in Charge, staff working in the centre, Director of Nursing and the wider Multi-Disciplinary Team attend regular compatibility meetings where the compatibility of residents within the centre is reviewed – Date for Completion 31/12/22
3. The Person in charge continues to attend monthly safeguarding meetings where any issues relating to safeguarding and compatibility are reviewed – Completion date 25/10/22

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	14/11/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	15/12/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	30/06/2023

	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.	Substantially Compliant	Yellow	30/06/2023
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	31/10/2022
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the	Substantially Compliant	Yellow	31/10/2022

	care and support provided to residents.			
Regulation 31(1)(f)	The person in 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.	Not Compliant	Orange	04/11/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022