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:	Riverside
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	10 October 2022 and 11 October 2022
Centre ID:	OSV-0008152
Fieldwork ID:	MON-0036793

About the designated centre

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

Riverside designated centre is located within a small campus setting which contains six other designated centres operated by the provider. Riverside can provide full-time residential care and support for up to six residents, both male and female. The home has two sitting rooms, one of which has patio doors with access to the garden, a visitor's room, kitchen, Jacuzzi bathroom, three shower rooms, two en-suite bedrooms and four-single bedrooms. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. There is also transport available for residents to access community outings. Residents are supported by a staff team of nurses and healthcare assistants who provide 24 hour support, with two waking night staff available to support residents with their needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 10 October 2022	14:00hrs to 19:15hrs	Angela McCormack	Lead
Tuesday 11 October 2022	09:30hrs to 14:30hrs	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 of Social Services 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 Health Information and Quality Authority (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 all of the 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. This will be discussed in the other sections of the report.

There were five residents living in Riverside at the time of inspection, with one vacancy. The inspector was informed that there were no plans for anyone to move into the centre and that an application to vary the conditions of the registration to reduce the bed numbers from six to five beds were in progress.

The inspector got the opportunity to meet with all residents over the course of the inspection. Residents greeted the inspector on their own terms and through their preferred communication methods, such as smiling, using gestures and some verbal communication. All residents required some degree of supports with communication. Staff supported residents with their communication needs and were observed to be treating residents with respect and dignity. Observations throughout the inspection indicated that residents appeared relaxed in their home environment and with staff.

On the first afternoon of the inspection, the inspector met with three residents who were supported by three staff. All residents appeared relaxed sitting in the main sitting-room together. One resident was reported to be visiting family and one other resident was reported to be attending an external day service. Residents interacted with the inspector on their own terms and with the support of staff.

The interior of the house was noted to be recently painted and the inspector was informed that new furniture had also been purchased for the main sitting-room. One

resident spoke about their involvement with picking out new curtains for the sitting-room. It was reported that residents were going to go for a bus drive in the afternoon to collect a fellow resident from their home visit. Later the inspector was informed that the group went for a drive to a seaside location in another county while out.

On the second day of inspection, the inspector met with one resident who had returned from a home visit the previous evening. They acknowledged the inspector but did not communicate further. They appeared happy and content and were observed smiling. They were going to a swimming lesson in a local hotel in the afternoon. One resident greeted the inspector and with staff support said that they were going to 'aqua aerobics' that morning and they made gestures to support their communication about this. They appeared happy that this was occurring and staff reported that the resident loved this activity and did it with a peer from a nearby centre. Later in the afternoon they were after observed walking around the house accompanied by staff and appeared to be enjoying eating a snack.

Throughout the inspection, the inspector got the opportunity to meet with staff. Staff spoken with described supports that residents required and reported that residents enjoy going out and about doing various activities. The inspector was informed about how two residents had started fishing, and it was observed that one resident was smiling and laughing when a member of staff spoke with them about this, which indicated their enjoyment of this. The inspector was also informed about how one resident had started swimming the previous week, after a few years not doing this. Staff described about how the resident was supported to engage in this new activity. They reported that the resident seemed to really enjoy it and that there were plans to continue this activity as long as the resident chose to continue with it.

Some residents were not compatible to live together and this was noted on safeguarding documentation, with a new formal safeguarding plan in place arising from a recent incident. Staff described interventions to help to reduce risks of a safeguarding nature between residents. This included consistent staff and staff being aware of possible triggers to a resident's behaviours that may impact on others. Staff spoken with appeared knowledgeable about supports required. In addition, the inspector was informed that having two modes of transport helped to reduce safeguarding concerns and allowed residents' more choices about individual activities.

Through a review of documentation, photographs and discussions with the management team it was evident that in general residents were supported with preferred activities and offered new opportunities for recreation. The management team were advocating for one resident to attend a day service on a full-time basis. In the meantime, residents had access to a 'hub' for activities that may be of interest to them. Other residents were reported to enjoy a slower pace of life in line with their age and stage of life, and this was facilitated. However, improvements were required in the review of one resident's person-centred plan and their identified goals to ensure that they were achieved in a timely manner and reviewed

appropriately.

The house was bright, clean and well ventilated. In general it was well maintained; however some doors and door frames were damaged and required repair. Plans were in progress to address this and this will be discussed further in the report. The kitchen area in the house was small. There were plans in place to address the accessibility of this. This had been an action from previous inspections by HIQA. This was now due to be completed by mid 2023. The kitchenette contained some cooking equipment and a fridge to store food items. Some upgrade work to the kitchen counter tops and cupboard presses were required and this was an action identified by the management team and was in progress. There was a separate utility area which stored laundry equipment, and which was accessible through the hallway. The utility door was missing the surround around the lock and this required replacement. This will be discussed in the next sections of the report.

The dining room had three sets of tables and chairs, a dresser and notice board which contained meal choices. Residents' two main meals were delivered from a centralised kitchen on the campus and residents were offered choices about what meals they would like to order each day. The notice board in the dining room had information to support them with making choices with visuals and pictures to support choices. Staff spoken with described how residents used this and about how alternative food was available in the centre itself. A review of the kitchenette found that cupboards and the fridge had plentiful supply of snacks and food items.

The house had a number of communal areas for the five residents to enjoy. Two residents were reported to recently enjoy spending time together in the smaller sitting-room. Each resident had their own bedroom with some bedrooms having en-suite facilities. Bedrooms observed were found to be personalised with photographs, art work and personal effects such as soft toys and music players. It was reported that residents' bedrooms were recently painted and that residents were being supported to choose new curtains and bedding. The communal bathrooms were large with level access showers and a Jacuzzi bath also.

Residents had access to DVD players, radio players and televisions in the house and in personal bedrooms in line with their wishes. A notice board on display in the hallway included information on complaints, safeguarding, and advocacy services and there was a visual roster showing what staff were working that day. In the hallway there was a large framed map of Ireland that had indicators and photographs of places that residents visited.

The garden area was spacious and well maintained. It contained garden furniture and a brightly painted mural of a tree on the external wall. The garden was also decorated with bright bird houses, painted stones and potted plants, which helped to create a relaxing space. The garden was accessible through double doors leading from the sitting room and dining room.

In general, the inspector found that the service strived to provide a safe and person-centred service to residents. However, some improvements were required to 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 the progress of actions arising from an inspection by HIQA in March 2022. Since April 2021, the provider was required to submit monthly updates about a management improvement plan to HIQA, and some of these actions were also reviewed. This inspection also reviewed actions included on the compliance plan from the overview report for CHO1, to monitor the progress of the actions and to assess the impact of these actions on the quality of care and support provided to residents.

Overall, improvements were found in the governance and oversight arrangements in Riverside since the previous inspection and since the implementation of the provider's actions as part of the overview report. However, further improvements were required in areas such as staffing, staff training, person-centred plan reviews, communication supports, premises and fire safety. These will be discussed throughout the report.

The local management team consisted of a person in charge who had responsibility for one other designated centre which was also located on the campus. They were supported in the operational management of the centre by a clinical nurse manager 1 (CNM1). Both the person in charge and CNM1 were available throughout the inspection, and both appeared knowledgeable about the needs of residents and specific service operations. Staff spoken with were complimentary of the management team and said that they were approachable and available for support when required.

The staffing skill mix in Riverside included nursing staff and healthcare assistants. A review of the roster showed that in general there were the numbers of staff working to meet the needs of residents. Some agency staff were used to fill staffing gaps, such as planned leave and sick leave however this was kept to a minimum and in general there was a cohort of regular agency staff used. A roster was maintained and included the planned and actual roster arrangements. However, the maintenance of the roster required improvements as it was not always accurate as to who was working. For example, on a day where a safeguarding incident occurred recently, the actual staff working on the day were not recorded on the roster.

The service had in place an induction folder for new staff that contained up-to-date relevant information required to support residents' needs. This also included reference to specific care plans and documents for further information. The induction documentation reviewed also showed that staff had to review and sign off on a checklist of policies, procedures and care plans while on induction. This demonstrated good practice in supporting any new staff to have the knowledge to

support residents and promote a safe service.

The provider had a list of mandatory training that all staff were required to complete. The person in charge developed an annual training plan for the year and there were two staff training matrices maintained; one for permanent staff and one for agency staff. A sample of training records was reviewed and in general demonstrated that staff members had competed the mandatory and refresher training as required. Some training modules were outstanding for some staff, however there were dates scheduled and plans in place to address this. For example; one staff required refresher manual handling training, one agency staff member required training in behaviour management and one staff nurse required training in the safe management of oxygen (which was an intervention to support a resident as part of their care plan) and a number of healthcare staff required training in the administration of an emergency medication. The training needs had been identified and included on the improvement plan for the centre and the person in charge spoke about their involvement in devising a protocol for the use of emergency medication to complement the staff training in this intervention. It was noted that training needs were kept under regular review by the management team and reviewed regularly at governance meetings at county, network and local level.

The centre had a quality improvement plan (QIP) in place which contained actions arising from provider audits, HIQA inspections and from a self-assessment tool used by the person in charge to monitor compliance with regulations. This was found to be comprehensive and was under weekly review, and sent to senior management for review and monitoring. However, this QIP did not include actions relating to fire doors, of which the inspector was informed and also observed to have been followed up recently. The person in charge updated this on the day to include the action in progress.

As part of the provider's actions to address governance and management issues arising from the overview report, they had identified the need for a review of the audits and schedule. The revised audits and schedule were implemented in Riverside on 23 August. This included audits in areas such as; personal plans, safeguarding, finances, medication, health and safety, fire safety and restrictive practices. A sample of local audits reviewed demonstrated good oversight by the local management team, with regular reviews of incidents and trending of incidents occurring. A review of incidents that occurred in the centre indicated that the person in charge had submitted notifications as required in the regulations for the Chief Inspector. In addition, there was good oversight of restrictive practices, where information was analysed noting if there was an increase or decrease in the use of restrictions. A safeguarding awareness audit tool was implemented also, where a member of the local management team reviewed staff awareness on safeguarding and this audit tool had a section to note comments, which was completed with areas of note by the auditor. However, the fire safety audit required improvements to ensure all actions were fully identified and that all staff had signed off on the fire safety documentation as required by the management team.

As part of their action plan from the overview report to strengthen the oversight and management systems the provider had implemented a number of governance

meetings. A sample of meeting minutes were reviewed including; the county level person in charge meetings (held fortnightly), and quality, risk and patient safety group (held quarterly) and the local governance meetings (held bi-monthly). However, it was found that the local governance meetings did not include all staff members. 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 action to improve governance and management was met. The local management team spoke about how this was currently under review in order to address this to try to ensure that all staff had the opportunity to attend the meetings.

The provider completed unannounced visits to the centre as required in the regulations. On the second day of inspection, a provider nominee arrived at the centre to do an unannounced visit. The last provider audit was completed in August and a report was available for review. In general, this was found to be comprehensive with actions for quality improvement noted, one of which included an action for all staff to agree meaningful activities that can be provided to residents during staff breaks. This demonstrated a human rights based approach by the provider to ensure that residents' rights and choices were upheld at times when reduced staffing was in place. A discussion with the person in charge indicated that this was under ongoing review and that they were monitoring that residents' choices about their meal times and activities were satisfactory to them, and not impacted by staff break times during the day.

However, some aspects of the provider audit required strengthening, particularly in relation to reviewing actions from previous inspections to ensure that the actions were completed fully, and within the time-line in which they were agreed with HIQA. For example, the provider report noted that all HIQA actions, with the exception of training, had been completed. However this was not accurate as some issues relating to premises and the full completion of all residents' assessments of communication needs were still in progress. In addition, both the provider audit and local fire audit failed to identify issues with the fire doors and this required review to ensure risks evident in the centre were reviewed effectively.

Overall, the inspector found the governance and management arrangements were good. However, improvements were required in staffing, training, staff meetings and in ensuring that audits were effective in reviewing progress on actions for compliance and in identifying areas for quality improvement.

Regulation 14: Persons in charge

The person in charge had the experience and qualifications to manage the centre. Arrangements in place supported the person in charge in ensuring good oversight of both centres under their responsibility.

Judgment: Compliant

Regulation 15: Staffing

In general the roster was well maintained; however it was found that on a day when a safeguarding incident occurred, the roster did not accurately reflect who was working that day.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Some training that was required to support residents with their needs was outstanding. This related to Buccal Midazalom for a number of healthcare staff, safe usage of oxygen and manual handling. The person in charge was aware of this and spoke about plans in place to address this.

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 all 11 actions had been completed, with minutes of meetings reviewed and the revised audits and schedule found to be in place. The person in charge spoke about their input and involvement with these meetings and discussed the benefit of this.

However, some improvements were required in Riverside to enhance the governance and management and in ensuring a safe and quality service as follows;

- Communication pathways required improvements, as while the provider had ensured a review had taken place on fire doors in July 2022, the person in charge had not received the relevant report about this which on follow up by the person in charge in October confirmed that all doors were to be replaced. This deficit in communication could impact on the local management of risks.
- Local and provider audits did not identify that some actions from the previous HIQA inspection were not completed within the agreed time frames. For example, there was no reference to the actions on premises and

communication which were still in progress and not fully completed.
- Team meetings did not include all staff members as outlined in the provider's response and action from the overview report.
- Improved oversight was required on the signing off of relevant documentation by staff. For example, the fire safety information which stated that all staff were required to read and sign off as understood, did not include all of the staff working in the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All notifications had been submitted to the Chief Inspector as required under the regulations.

Judgment: Compliant

Quality and safety

Overall the inspector found that residents were supported with their needs and were provided with care that promoted their safety and general wellbeing. However, some improvements were required in the ongoing review of some person-centred plans, premises and fire safety, which would further enhance the quality of care and support provided.

A sample of residents' files reviewed found that residents had assessments of needs completed to assess their health, personal and social care needs. There were a range of care and support plans in place to support with these assessed needs and guide staff. Annual review meetings occurred, however one sample did not note if the resident attended or not. This required review to ensure that it was clear that the maximum participation of residents at their meetings occurred.

Each resident had a person-centred folder in place, which contained identified goals and photographs of achievements. A sample of person-centred plans were reviewed and it was found that one resident's person-centred plan had not been reviewed in over a year and some goals had not been achieved in a timely manner, or reviewed as to its' effectiveness. For example; one resident set a goal in June 2021 to meet with a family member and there was no noted progress on this since August 2021. This required improvements to ensure that all residents' goals were kept under review for achievement.

Residents that required supports with behaviours of concern had positive behaviour support plans in place. These had recently been reviewed with the relevant

members of the multidisciplinary team (MDT). Positive behaviour support plans were found to be comprehensive and clearly outlined triggers to behaviours and the specific supports and interventions required. Staff spoken with were aware of how to support residents' with behaviours that may indicate anxiety and could impact on others.

Restrictive practices were reviewed and found to be kept under regular review by the person in charge and included in the auditing schedule, as noted previously. There was a risk assessment completed for restrictive practices and the person in charge kept a detailed record of the use of restrictive practices, which included a clear rationale for its use and with consideration being given to the human rights of the residents for whom the intervention was assessed as required. These actions demonstrated good monitoring of restrictive practices to ensure that they were appropriate to the risks identified, and to ensure that they were the least restrictive option.

Safeguarding of residents was promoted through staff training, reviews of incidents that occurred and the implementation of safeguarding plans where required. A review of incidents in the centre demonstrated that possible causes of risks were reviewed and debriefing meetings took place with the staff team after a safeguarding concern arose. Staff spoken with were aware of potential safeguarding risks and about how to minimise these risks, which included environmental strategies such as the use of separate rooms and separate transport for some residents. Compatibility issues in Riverside were kept under review at meetings to review compatibility between residents for the future.

There was one open safeguarding plan in place which had recently been developed and was available for review. The person in charge demonstrated how safeguarding plans were reviewed and monitored through the 'safeguarding tracker log', which was maintained at network level. Minutes of safeguarding meetings were available for review which demonstrated that centre specific safeguarding issues were kept under review at the 'Safeguarding Review' meetings also, which were part of the provider's actions from the overview report.

Residents' human rights were promoted through discussions at residents' meetings, and at local staff meetings where one meeting note emphasised that choices must always be provided to residents. Residents' meetings reflected choices offered about meals and activities, and also noted how staff interpreted residents' satisfaction at choices offered such as through smiling, gestures etc. The provider had in place a Human Rights Committee which met regularly, and work was in progress to further establish this committee to further support a rights based approach to service provision. Staff had been trained in the area of 'Human Rights' and staff spoken with described about the importance of offering choices to residents and about enabling residents to make choices about their lives.

All residents in Riverside required some degree of supports with their communication preferences. An action from the previous inspection in March 2022 said that all residents would be fully assessed for communication supports by the end of April 2022. While initial assessments had been completed for all residents,

due to capacity issues a prioritisation list had been established, of which two residents in Riverside had been placed as a high priority, therefore not all residents had full assessments completed as noted in the compliance plan. It was reported that some work had been done with the MDT for one resident with regard to visual schedules and this was still under review. However, all residents in Riverside require a full assessment of their communication needs to support them to communicate through their preferred method and to ensure that their will and preference are heard and understood at all times.

There were measures in place for fire safety. Fire drills were occurring regularly and demonstrated that residents could be evacuated to a safe location. A fire policy which detailed the plans for evacuation of the centre and supports required. All residents had up-to-date evacuation plans in place also. However the fire doors in the utility and kitchen had some visible damage. While it was reported that an assessment of the doors this had been completed in July, however the person in charge had only received this confirmation about the need for their replacement in October after they sought an update. Communications about fire safety and actions to improve this required improvements to ensure that the person in charge was fully informed when assessing fire risks.

Regular fire checks and fire safety audits were completed locally also. A fire book was in place which contained a schedule of weekly, monthly and bi-annually checks to be recorded. However there were some gaps in the documentation. For example, the location of the fire extinguishers section on the fire book had not been completed, with did not give assurances that the checks on fire equipment were effective. In addition, the fire folder had not been signed as read, as required by all staff working in the centre.

In summary, while the service strived to ensure residents' safety and wellbeing some improvements were required as noted above which would further improve the quality of care and support provided.

Regulation 10: Communication

The action from the previous HIQA inspection stated that all five residents would be fully assessed by the Speech and Language Department by the end of April 2022. While it was reported that all residents had had an initial assessment by the speech and language therapist (SALT) for communication supports, the local management team were not aware what recommendations or further supports, if any, had been identified and there was no evidence of the assessments on the residents' files. Following a phone call by the person in charge to the SALT on the day, it was confirmed that two residents were prioritised for further interventions and a meeting was then planned for the following day with the person in charge and SALT to review the next steps.

Judgment: Substantially compliant

Regulation 17: Premises

Some issues relating to the premises were outstanding since the previous inspection by HIQA. These related to;

- Accessibility issues for the kitchenette. It was reported that plans were in progress to address this, with a completion date of end of June 2023.
- Two fire doors (kitchen and utility doors) were visibly damaged, and while there were now plans in place to address this, the completion of this remained outstanding.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The management of risk was found to be good overall. There was a policy and procedure for risk management and a risk register was developed which included identified centre risks. In addition, risks identified for residents had been assessed with plans in place to mitigate risks. These were found to be kept under regular review by the local management team and updated as required.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety required improvements in the following areas:

- Fire audits did not effectively identify issues with some fire doors.
- While weekly audits were carried out on fire equipment, the location of the fire fighting equipment was not documented on the relevant fire documentation, which did not provide assurances that all equipment was effectively reviewed.
- Fire documentation that was required to be signed as understood by staff members, had not been signed by all staff working in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A sample of personal plans reviewed found that one resident's personal goals identified through the person-centred planning process had not all been achieved and there was no progress notes or review of identified goals since August 2021. In addition, it was not clear from a record of a meeting reviewed if a resident had attended their annual review meeting or not.

Judgment: Substantially 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. The inspector reviewed six actions which were found to be completed. In relation to the recruitment of additional MDT posts, the inspector was informed on the day that two new MDT posts in speech and language therapy had been progressed.

Behaviour support plans were in place in Riverside for residents who required these, which had a MDT input also. There were good systems in place by the local management team to review restrictive practices on an ongoing basis to ensure that they were proportionate to the risks identified and that they were the least restrictive option for the shortest duration.

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 11 actions at this time, with ten being completed. At the time of the inspection one action was still in progress, relating to the 'Policy on the provision of safe WiFi usage'. The safeguarding review meetings had been implemented and the person in charge spoke about the benefit of this in sharing information and provided opportunities for shared learning from safeguarding concerns.

In Riverside, safeguarding issues were found to have been appropriately identified and the safeguarding procedures followed. Safeguarding plans were in place, and were clear on the measures to minimise concerns. However, while measures were in

place to minimise safeguarding incidents, there remained incompatibility between residents living in Riverside, which would only be addressed through residents not living together. Compatibility between residents was under ongoing review by the management team.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights were promoted in the centre through staff training on human rights and discussions at resident and manager meetings. Residents were also supported to access independent advocacy services. Staff spoken with talked about how important it was to enable residents to make choices in their lives and felt that their training in 'Human Rights' had emphasised the importance of this.

While main meals were still being received from a centralised kitchen on the campus, residents were offered choices about what to have for these meals and alternatives were available if required. Pictures were used to help residents to make choices about meals.

The provider had identified in the most recent unannounced visit that a review was required to ensure that meaningful activities took place at times when staff were on breaks. Through a discussion with the person in charge, they said that they were not aware that residents' choices about the times that they have meals or preferred activities were impacted by the staff's daily schedule of breaks. They said that they would keep this under review to ensure that residents' rights were upheld at all times.

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 14: Persons in charge	Compliant
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	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Riverside OSV-0008152

Inspection ID: MON-0036793

Date of inspection: 10/10/2022 and 11/10/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC will ensure that off-duty rosters are updated daily by the staff on duty to take into consideration any changes in staffing during a shift. Completed by 20/12/2022. 1. The Person in charge will ensure that the off duty in Riverside is reflective of the staff that are on duty at all times – Date completed 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 ensured that the Staff Nurse who require to complete 'safe management of oxygen' module on HSELand has completed same. Date completed 31/10/2022. 2. The Person in charge will ensure that the 1 staff member who is out of date for Studio 3 training will have same completed. Date for completion 30/11/22. 3. The person in Charge will schedule all staff for outstanding training with emphasis on Buccal Midazolam and manual handling. Date for completion 30/01/23 4. The Person in charge will continue to monitor the staff training matrix on a monthly basis and schedule training as required. Completion date: 31/10/22	

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 will discuss with maintenance manager the requirement for the centre to receive a copy of all reports in relation to Riverside and establish a pathway for this. Date for completion: 30/11/22.

2. The Person in charge will ensure that staff meetings are scheduled bi-monthly in Riverside with a standing agenda and the opportunity for staff to include items on the agenda. Date for completion: 30/11/22.

3. 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. Completion date: 17/11/22

4. The Person in charge will ensure that a copy of Staff meetings will be printed in a timely manner following meeting and all staff will be requested to read and sign off on meeting minutes. Date for completion: 30/11/22.

5. The Director of Nursing in liaison with the provider will ensure that local and provider reports include all information/actions relating to the centre with emphasis on a follow up on outstanding actions from previous HIQA inspections. Completion date: 31/10/22

6. The Person in charge will ensure that all staff working within the centre sign off on relevant documentation with particular emphasis on the fire safety log book. Completion date: 31/10/22

7. The person in charge will ensure that all audits are completed and all actions are included on the centres quality improvement plan. Completion date: 31/10/22

8. The Person in charge will ensure that all improvements required within the centre will be included on the centres Quality Improvement Plan (QIP) – Completed 31/10/22

9. The Person in charge in liaison with the director of nursing will review the centres QIP on a weekly basis and submit to the regional director of Nursing for weekly review – Completed 31/10/22

7. The person in charge will ensure that all audits are completed and all actions are included on the centres quality improvement plan. Completion date: 31/10/22

8. The Person in charge will ensure that all improvements required within the centre will be included on the centres Quality Improvement Plan (QIP) – Completed 31/10/22

9. The Person in charge in liaison with the director of nursing will review the centres QIP on a weekly basis and submit to the regional director of Nursing for weekly review – Completed 31/10/22

Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: 1. The Person in charge will ensure that all residents' recommendations for communication input and further supports will be available in resident's personal plans to guide staff in supporting the residents. Date for completion 30/11/22. 2. The Person in charge will ensure that all residents have a full assessment of their communication needs completed by the speech and language therapist and that all recommendations and interventions are discussed with staff and a copy available in the resident's personal plans. Date for completion: 28/02/23	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. The registered provider will ensure that interim works will be completed in the upgrading of the kitchen area in Riverside centre and an accessible food preparation area is in place for all residents use. Date for completion 05/12/22 2. The kitchenette in riverside is in phase 2 of the works to extend the current kitchenette with an anticipated completion date of Quarter 3 2024. Date for completion 30/09/24 3. The person in charge has linked with the maintenance manager for an update and the fire doors have been ordered and are scheduled to be fitted by 30/11/2022. Date for completion: 30/11/22. 4. The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. Date for completion 31/12/22	

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. The person in charge has linked with the maintenance manager for an update and the fire doors have been ordered and are scheduled to be fitted by 30/11/2022. Date for completion: 30/11/22. 2. The person in charge has ensured that Riverside's fire safety log book is completed in its entirety and clearly identifies the number of fire extinguishers within Riverside, including type of extinguisher. Completion date: 31/10/22. 3. The Person in charge will ensure that all staff working in the centre sign off on relevant documentation in relation to fire safety with particular emphasis on the fire safety log book. Completion date: 31/10/22 4. The person in charge will ensure that fire safety audits are completed effectively and will ensure that all actions are included and monitored on the centres Quality improvement plan. Date for completion 30/11/22	
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: 1. The person in charge will ensure that all residents' annual reviews reflect that residents have been given the opportunity to participate and be involved in their annual review and whether they were in attendance. Date for completion 30/11/22. 2. The person in charge in liaison with the named nurses will review all residents Person Centred Plans to ensure that the goals are meaningful, achievable, up to date and that progress notes are completed at least monthly. Date for completion 30/11/22.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • 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 • 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 • 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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	28/02/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/10/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/01/2023

Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2024
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	31/12/2024
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	30/11/2022
Regulation 23(3)(b)	The registered provider shall	Substantially Compliant	Yellow	30/11/2022

	ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	30/11/2022
Regulation 05(6)(b)	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 be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/11/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a	Substantially Compliant	Yellow	30/11/2022

	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.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022