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:	Finnside
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	18 October 2022
Centre ID:	OSV-0008153
Fieldwork ID:	MON-0036795

About the designated centre

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

Finnside designated centre is located within a small campus setting which contains six other designated centres operated by the provider. Finnside can provide full-time residential care and support for up to four residents, both male and female. Finnside consists of two sitting rooms, one of which has patio doors with access to the garden, a dining-room, a visitor's room, kitchen, Jacuzzi bathroom, three shower rooms, two en-suite bedrooms and four single bedrooms. A laundry room is available where each resident if they choose can participate in their laundry. 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 in place each night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 18 October 2022	14:00hrs to 18:50hrs	Angela McCormack	Lead
Wednesday 19 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 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. This will be discussed in the other sections of the report.

The centre was one of seven designated centres located on a campus based setting. There were three residents living in Finnside, with one vacancy. The inspector was informed that there were no plans to fill this vacancy. The house was being redecorated at the time of the inspection; therefore residents were attending a 'hub' and doing activities in the community during the day and returning to the centre in the evening when the decorators had left. One resident attended an outpatient medical appointment with support of staff during the day, which was reported to have gone well. The inspector got the opportunity to meet with all residents during the evening of the first day of the inspection, and briefly met with two residents as they were getting on to their transport the following morning. The inspector also met with staff in the centre during the first evening, and carried out a documentation review and meetings with management in a separate location on the campus due to the internal decorating works in the centre.

The house was spacious to meet the needs of the three residents. The centre had experienced the death of three residents over the previous two years and it was observed that there was a ‘memory table’ set up in the hallway for the deceased residents. Since the last inspection, three trees had been planted in the garden in memory of the deceased residents. The inspector was informed that the centre held a memorial service during the Summer and this was reported to have gone well, with residents actively involved in the planning of this.

The garden also contained garden furniture, garden ornaments and some potted herbs and shrubs. It was reported and noted in documentation that the planted herbs were introduced as part of sensory programme for one resident. The garden was accessible through double doors leading from the main sitting-room and dining room. The house had Halloween decorations on display and the inspector was informed that there was a Halloween competition on the campus for the best decorated house.

As stated previously the internal walls of the house was being painted, therefore a brief walkaround took place on the first evening only. The house was observed to be clean, bright and well ventilated. There were framed photographs on display throughout the home and a staff photograph roster was located in the hallway. There were notice boards with information for staff and residents including easy-to-read information about various topics.

Each resident had their own bedroom which were personalised to their individual tastes. There were communal bathrooms with level access shower rooms and a Jacuzzi bath, which some residents were reported to enjoy using. There was a separate utility room which contained laundry equipment and was accessible through the hallway. There was a visitor room and two sitting-rooms in addition to a dining-room which had a dresser, cupboards and sets of tables and chairs. The kitchen was small and there were plans in progress to redesign this in the future to improve accessibility. This will be discussed in a further section of the report.

All residents in Finnside required supports with communication and staff spoken with described how residents chose to communicate, which included some verbal communication, making requests through a personal soft toy, the use of objects of reference and gestures. Some residents had mobility needs also and one resident had sight issues. Staff described how the past few years had been difficult for one resident in particular, due to changes that had occurred to their physical health and the staff member spoke about the supports provided. They also described about how the death of peers had affected some residents. It was evident in documentation that residents were supported to try to understand this loss and were actively involved in creating memories and having open discussions about the loss. Staff were observed to be supporting residents in line with their assessed needs, care plans and communication preferences throughout the inspection. Consistent and familiar staff were noted to be important in supporting residents with anxiety related behaviours, with mobility and with communication. At times, staffing issues occurred which could impact on continuity of care. This will be discussed later in the report.

It was noted in documentation and staff spoke about how some residents' behaviours could impact on other residents' quiet enjoyment of their home. There was a safeguarding plan in place arising from an incident that occurred in April. In general, the use of the environment and separate transport helped to ensure safeguarding risks were reduced. However, the inspector was informed that compatibility between residents was being reviewed as part of meetings related to the campus overall.

Residents interacted with the inspector on their own terms and with the support of staff. They were observed to be relaxed in their home. One resident was observed relaxing in the dining room with staff while listening to a favorite programme on YouTube on their mobile phone. They greeted the inspector and mentioned about a deceased peer. Staff reassured the resident. With support of staff the resident spoke about the personal items that they had with them and talked about how a family member had given them a gift of a soft toy. Later they were observed flicking through a magazine while sitting at the dining room table.

Another resident was relaxing in the sitting-room looking out the front window. They appeared content and they smiled when the inspector admired their jewellery and hair accessory. They were observed looking through a shopping leaflet and at times appeared reluctant to interact with the inspector and this was respected. Another resident had gone for a walk with staff in the evening, and the inspector met them later after they had returned. They were noted to be dressed for bed and appeared relaxed in the sitting-room. They interacted briefly with the inspector and ended the interaction by indicating to the inspector it was time for them to leave, by saying 'cheerio', and this was respected.

Through a review of documentation, person-centred plans and discussions with staff and the management team, it was evident that residents enjoyed activities and outings in line with their wishes, stages of life and developmental needs. One resident attended a day service one day per week and residents could also access outings and programmes in a nearby 'hub' run by the provider. Two residents attended the 'hub' on the day of inspection and staff spoke about how they had gone out for tea and were having their dinner out during the 2nd day of inspection while at the hub. A review of person-centred plans described activities that residents enjoyed including; overnight stays in hotels, going to tourist attractions, walking alpacas and getting involved in their local community through parish activities. Residents also enjoyed having meals out, listening to music, gardening activities, baking and going to the hairdresser regularly. Photographs reviewed in personal plans indicated residents' enjoyment of these activities.

In general, the inspector found that the service strived to provide a good quality and person-centred service to residents. However, some improvements were required which would enhance the good care provided. These will be discussed throughout the report. The following sections of the report also outlines 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 March 2022. The inspector also reviewed actions included on the compliance plan from the

overview report for CHO1, as mentioned previously. In addition, the provider was required to submit monthly updates about a management improvement plan for the campus to HIQA since April 2021, and some of these actions were also reviewed.

Overall, improvements were found in the management and oversight arrangements in Finnside. There was a good governance structure and improved systems in place to support more effective monitoring by the management team. However, further improvements were required in areas such as staffing, staff training, fire safety and ensuring follow up communication assessments were completed for all residents. 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 reported to the director of nursing (DON). They were supported in the operational management of both centres under their responsibility by a clinical nurse manager 1 (CNM1). Both the person in charge and CNM1 were available during the inspection. The person in charge was knowledgeable about the needs of residents living in Finnside and spoke about their ongoing work to improve the quality of service since they took over as person in charge this year. Staff spoken with were complimentary of the local management team and said that they were available, supportive and approachable.

The staffing skill mix in Finnside included nursing staff and healthcare assistants, with at least four staff working during the day and two waking staff in place at night. A review of the roster indicated that there was the numbers of staff working each day to meet the needs of residents. However, some regular agency staff were used to fill staffing gaps, such as planned leave, sick leave etc and at times it was found that additional staff from other centres on the campus were required to cover some absences. For example; it was noted that on one day in September four of the five staff working during the day to cover absences were not permanent or regular agency staff. This required review to ensure that continuity of care provided to residents was not impacted. The continuity of care and support provided by staff was particularly important in the centre as it was noted in one residents' care plan that three familiar staff were required to support with personal care needs each day in order to support the resident with identified behaviours of concern and distress during this aspect of care. In addition, it was found that at times staff from Finnside were required to support in other designated centres which also impacted the continuity of care. A risk assessment had been put in place to minimise the associated risks of this, and included control measures regarding the arrangements for when a staff nurse was required to oversee two designated centres on the campus.

Staff were provided with opportunities for ongoing professional development. The provider had a list of mandatory training programmes that staff were required to complete. This included safeguarding, human rights, behaviour management, cardio pulmonary resuscitation (CPR) and hand hygiene, to name a few. The centre had a site specific training list to supplement the mandatory training programmes, and this included clamping and sexuality awareness in supported settings (SASS). The provider's mandatory training list was recently updated to include training on the

'National Consent policy' and 'Supported decision making', and staff were in the process of completing this training.

The person in charge monitored staff training through a training matrix which included information about when staff had completed training and if they were due refresher training. There were two matrices maintained; one for permanent staff and one for agency staff. Both were reviewed and in general most training had been completed by staff, with plans in place for any outstanding training. Outstanding training required included; CPR, Behaviour Management, clamping and hand hygiene for some staff. These training needs had been identified by the person in charge and dates had either been set, or the person in charge was awaiting dates for same. These actions related to staff training had also been included on the centre's quality improvement plan (QIP).

The centre's QIP included actions from HIQA inspections, provider audits and person in charge's audits. It was found to be comprehensive and kept under review with outstanding actions noted. The local management team carried out a range of audits some of which included; audits on incidents, finances, medication, personal plans, restrictive practices and health and safety. A new audit schedule and audit templates had recently been implemented in the centre. This had been an action from the provider overview report for CHO1 and had been implemented in Finnside in September 2022. A sample of audits reviewed demonstrated good oversight and monitoring by the local management team, where trending of incidents occurred and possible causes for incidents analysed so that learning could be taken. A review of incidents and practices in the centre indicated that the person in charge had submitted all notifications to the Chief Inspector of Social Services as required in the regulations.

The provider's monitoring of the centre included unannounced audits as required in the regulations. The last unannounced visit occurred in July 2022. In general, this was found to be comprehensive with reviews of incidents, staffing and safeguarding occurring and actions for quality improvement identified. However, some improvements were required to ensure that a review of actions agreed with HIQA as part of the compliance plan for the centre was fully reviewed and to ensure that the audit report accurately reflected practices in the centre. For example; there was incorrect information regarding the use of some restrictive practices in the centre, which had not been identified by any of the management team, which could impact on the effectiveness of the quality improvement actions.

The inspector also reviewed some of the actions outlined in the provider's overview report for CHO1. The provider had implemented a number of management meetings and committees as part of their action plan to strengthen the oversight and monitoring of practices. A sample of meeting minutes were reviewed on this 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). On discussion with the management team, both the person in charge and director of nursing said that they found these meetings beneficial for shared learning among services. A review of the staff meetings for Finnside found that they covered a rnage of topics including training, safegaurding, residents' needs

and health and safety issues, however they did not include all staff members working in the centre. The local management team spoke about how this was under review to ensure the participation of all staff at the local team meetings in the future, and as agreed in the actions contained on the provider's plan from the overview report.

Overall, the inspector found that the governance and management arrangements in Finnside were good. However, improvements were required in staffing and staff training, and in ensuring that provider audits were more effective.

Regulation 14: Persons in charge

The person in charge had the qualifications and experience to manage the designated centre. Arrangements in place ensured that the person in charge could effectively manage two designated centres on the campus. They were knowledgeable about he needs of residents and it was evident that residents were familiar with them.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual staff roster was maintained, which accurately reflected who was working on the days of inspection. A review of the roster indicated that there were the numbers of staff in place to support residents with their needs. However, the staffing arrangements for providing cover during planned and other absences required improvements to ensure continuity of care to residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Some mandatory staff training was outstanding, and while there were plans in place to address this, there remained some gaps at the time of inspection. This related to: CPR for three staff, behaviour management for two staff and some infection prevention and control (IPC) related training for one staff who recently returned after a period of absence. The site specific training plan in place required some staff to be trained in 'clamping, lift and equipment training' and SASS for one staff. Dates were being sought by the management team for 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 some of the meetings reviewed and the revised audits and schedule found to be in place. The person in charge and director of nursing spoke about their input and involvement with these meetings and discussed the benefit of these in sharing learning between centres.

However, some improvements were required in Finnside in the following areas;

- More effective oversight by the provider in the unannounced visits to include a review of the progress of actions agreed with HIQA as part of the compliance plan from previous inspection, and to ensure that restrictive practices were appropriately reviewed and documented.
- To put in place a plan for all staff to attend the local governance meetings in line with the provider's actions in the overview report to ensure that staff are provided with opportunities to raise issues for discussion about the quality and safety of care in the centre.
- To ensure that all documents that were required to be reviewed and signed off by staff are completed, as required. For example; a small number of staff had not signed off as read a positive behaviour support plan in place for one resident, as required.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of incidents that occurred in the centre demonstrated that the person in charge submitted all notifications to the Chief Inspector in line with the regulations.

Judgment: Compliant

Quality and safety

The inspector found that residents living in Finnside were provided with care that promoted their safety, rights, health and wellbeing. However, some improvements were required in follow up assessments for communication supports, in some aspects of protection and premises, and in the review of fire drills. These areas for improvement would further enhance the quality of care and safety provided.

Residents' personal files and person-centred plans were reviewed. The inspector found that residents had comprehensive assessments of needs completed on their health, personal and social care needs. Up-to-date care plans were in place to guide staff in supporting residents' with their individual needs. Residents had annual review meetings and person-centred meetings completed, which included consultation with residents and their family representatives where relevant. Residents had person- centred plans (PCP) where individual goals for the future were identified and were kept under review for achievement. The PCP folders contained photographs of goals achieved. Some personal goals achieved recently included; an overnight stay in a hotel, visiting tourist attractions, walking alpacas, creating a window box for bedroom windows and becoming more involved in parish based activities within their religious community.

A review of care plans in place and discussions with staff about residents' needs found that residents were supported to achieve the best possible health. Staff spoken with were knowledgeable about residents' specific needs and about what was contained in care plans. In addition, there was supplementary information accessible in resident files to support further knowledge and understanding of specific health issues. Residents were supported to access allied healthcare professionals and national screening programmes as required and it was noted that residents' choices about whether to get vaccinations or scans were respected also. Residents also had access to multidisciplinary supports such as psychology services, behaviour support specialists, occupational therapists (OT) and speech and language therapists (SALT). However, due to capacity issues, not all residents had been fully assessed with regard to their communication needs. Each resident had had an initial assessment by a SALT and a prioritization list was developed, with one resident in Finnside being listed as a high priority. However, all residents living in Finnside required some level of support with communication. For example, it was noted in one resident's OT report that the use of technology to aid communication may be of benefit to them in expressing themselves. This required further review to ensure that all residents were assisted and supported to communicate their needs and wishes at all times. In addition, the recommendations from the sensory OT report for one resident required follow up as the resident chose not to engage in some aspects of the recommended interventions. The person in charge confirmed that this was planned to be reviewed as to its' effectiveness.

Residents that required supports with behaviours of concern had positive behaviour support plans in place that had recently been reviewed with the relevant members of the MDT. Plans were comprehensive and clearly outlined triggers to behaviours and noted that consideration was to be given to possible physical causes of distress that may be displayed. This plan also outlined the importance of familiar staff to support with personal care needs. In addition, there was a crisis management plan which had recently been reviewed and outlined where, and when, a physical

restrictive intervention should be utilised to support a resident. This intervention was not recorded on the restrictive practice log as yet, and the person in charge said that they had planned to include this and include its' use on the next notifications to the Chief Inspector. Restrictive practices were found to be kept under review by the person in charge and risk assessed also.

It was found that safeguarding of residents was promoted in the centre. Staff were trained in safeguarding vulnerable adults and staff spoken with were knowledgeable about what to do in the event that a safeguarding concern arose. A safeguarding concern arose in April between two residents and a safeguarding plan had been put in place with actions included to minimise the impact of one residents' behaviours on the other. This included measures such as the use of separate transport. In addition, all residents had an up-to-date overarching safeguarding plan which detailed how they could be at risk of being impacted negatively by peers. Compatibility of residents was under review at compatibility meetings that occurred regarding the overall campus.

The inspector found that a human rights based approach was being promoted in the centre. Staff undertook training in 'human rights' and on discussion with the local management team, they spoke about how they noticed a more rights based approach to care occurring since the training. Residents' meetings occurred regularly, where choices were offered about activities, meals and shopping items. These meetings were kept under review by the person in charge who signed them off when read. Residents were supported to access independent advocacy services. The provider also had a Human Rights Committee in place, minutes of which were reviewed, and demonstrated that discussions occurred and actions were identified about issues that could impact human rights, such as consent and restrictive practices.

At the time of the inspection, the centre was being painted internally so a brief walkaround of the centre took place on the first evening of the inspection. The premises was spacious to meet the needs of the three residents and each resident had their own bedrooms which had ample storage and were decorated with personal effects. However, an issue found in the previous HIQA inspections regarding the accessibility of the kitchen area due to it's size, was not yet addressed and remained in progress. The time-frame to address this was now identified for the end of June 2023.

There were good risk management processes in place in the centre which included up-to-date safety statements and emergency plans. A risk register was maintained and found to be comprehensive. Risks had been identified and assessed, and were found to be kept under regular review. These included centre specific risks and risks affecting residents. A risk of a reduction of nursing staff numbers had been identified and assessed, and the management team spoke about control measures in place to include a working group to review this issue on the overall campus.

A review of fire safety documentation found that there were systems in place for checking of fire equipment and fire safety procedures. In addition, the local management team kept a record of any maintenance requests and the outcome of

any fire checks by external contractors so as to ensure that any follow up actions were clearly recorded and the progress on these noted. This ensured effective oversight of works required or in progress in the absence of, and delays, of any reports from external contractors or maintenance personnel. Residents had personal emergency evacuation plans (PEEPS) completed and regular fire drills occurred. However, improvements were required in the follow up actions identified by staff during a fire drill. For example, it was noted that a staff member raised a possible issue following a fire drill in May under minimum staffing levels, and there was no further fire drill under this scenario completed since to provide assurances that residents could be safely evacuated in a timely manner when there were only two staff on duty. The person in charge undertook to follow this up after the inspection.

In summary, Finnside was found to be a service that strived to ensure residents' rights, health and overall wellbeing. Improvements as outlined throughout the report would further enhance residents' safety and the quality of care provided.

Regulation 10: Communication

Residents had communication dictionaries in place to guide staff in how to support communication preferences, However, residents required follow up assessments for communication supports in order to further support them to communicate through their preferred communication methods and to assess if assistive technology or other forms of augmented communication methods would be beneficial.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The management of risk was found to be good in Finnside, with systems in place for the identification, assessment and ongoing review of centre specific and individual resident risks.

Judgment: Compliant

Regulation 28: Fire precautions

In general, fire safety management was good, with regular checks in place of the fire safety systems and up-to-date documentation. However, the reviews of fire drills required improvements to ensure that possible areas of concern as identified by staff involved in drills were followed up appropriately.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had comprehensive assessments completed of their health, personal and social care needs. Assessed needs were kept under review and annual meetings occurred to review needs and identify goals for the future.

Judgment: Compliant

Regulation 6: Health care

Residents were supported and facilitated to attend healthcare professionals and national screening programmes as required and in line with their wishes.

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. The inspector reviewed six actions which were found to be completed. In relation to the recruitment of additional MDT posts, the inspector was informed that these identified posts were near completion.

Behaviour support plans that were reviewed for residents in Finnside were found to be comprehensive and up-to-date and had input from the relevant MDT member. 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.

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 12 actions at this time, with 11 being completed. At the time of the inspection one action was still in progress. This related to the 'Policy on the provision of safe WiFi usage'.

The management team spoke about how the safeguarding review meetings were of benefit to them in learning from other centres where safeguarding concerns arose. In addition, as part of the revised audit schedule, there was a comprehensive audit template on safeguarding that was to be completed annually in the centre. This audit covered many topics that could be impacted by, or contribute to, safeguarding concerns including; human rights, staff turnover, restraint, behaviour plans etc. This was due to be completed in the centre.

Safeguarding of residents were found to be promoted in Finnside with concerns 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 and incidents were not occurring frequently, there were incompatibilities between some residents. Compatibility between residents was reported to be under ongoing review by the management team

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights were promoted in the centre through staff training in human rights, regular resident meetings where rights were discussed through access to independent advocacy services and through respecting residents' religious beliefs and choices about care needs.

While the two daily main meals were still delivered from a centralised kitchen located on the campus, residents were offered choices in what meals they had each day and alternatives were available in the centre also, if required.

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 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially 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 Finnside OSV-0008153

Inspection ID: MON-0036795

Date of inspection: 19/10/2022

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: 1. The Person in Charge will ensure that the centre's roster is reviewed daily to ensure it is reflective of the staff on duty daily – Completion date: 30/10/22 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 15/12/22 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 30/10/22 4. The Director of Nursing in liaison with the person in charge will complete a support needs assessment for all residents within the centre – Date for completion: 31/12/22	
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 all staff including dedicated agency staff are included – Date for completion 30/11/22 2. The Person in charge will schedule refresher training with emphasis on CPR for three staff, Studio 3 for two staff, and Infection control (IPC) related training for one staff – Date for completion: 31/12/22 3. The Person in charge will review the site specific training matrix to ensure that all staff are trained in clamping, lift and equipment training and SASS. – Date for completion: 31/12/2022 4. 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 10/11/22
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 on a weekly basis and the director of nursing will monitor it monthly. Completed 01/11/22
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
6. The Person in charge will ensure a full review of all restrictive practices within the Centre is carried out. Date for completion: 30/11/22
7. The Person in charge will ensure that all documents that require to be reviewed and signed off by staff are completed, as required including a small number of staff who had not signed off as read a positive behaviour support plan in place for one resident, as required. Date for completion: 30/11/22
8. The Director of Nursing in liaison with the provider will ensure that 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

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 have a full assessment of their communication needs and requirement for assisted technology completed by the speech and language therapist. All recommendations and interventions will be discussed with staff and a copy available in the resident's personal plans. Date for completion: 28/02/23

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 ensured that a night time fire drill has been completed to assess the risks of staff evacuating residents at night during a fire drill. Completed 15/11/22
2) The Person in charge has ensured that Residents personal evacuation plans are reviewed and updated following the night time fire drill. Completed 15/11/22
3) The Person in Charge has ensured that the the reviews of fire drills will take place to ensure that any staff concerns identified that require improvements are followed up appropriately and in a timely manner. Completed 15/11/22

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 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	28/02/2022
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	31/12/2022
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	Substantially Compliant	Yellow	31/12/2022

	development programme.			
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 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.	Substantially Compliant	Yellow	30/11/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	15/11/2022
Regulation 08(2)	The registered provider shall protect residents	Substantially Compliant	Yellow	31/12/2022

	from all forms of abuse.			