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:	James Connolly Memorial Residential Unit
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	22 August 2024
Centre ID:	OSV-0002502
Fieldwork ID:	MON-0044635

About the designated centre

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

James Connolly Memorial Residential Unit is a congregated setting providing care and support to 9 adults with disabilities (both male and female) in Co. Donegal. The premises consist of a large two storey building and is institutional in design. Communal facilities include two large sleeping dormitories (one female and one male). There are also single occupancy bedrooms. All bedroom facilities are on the ground floor of the centre. A large bright sitting/TV room, multiple bathroom/restroom facilities, a relaxation/sensory area, dining rooms and a small kitchenette which is available for residents to use are also located on the ground floor. There is also a larger industrial-style kitchen on the ground floor (not accessible to the residents) that provides meals at specific times throughout the day to residents. The second floor has facilities for management and staff of the centre including offices, a kitchen, a staff dining area and staff restroom. The centre is located on a site from which a range of other Health Service Executive (HSE) services are accommodated. The building is surrounded by gardens and grounds that are well-maintained and private parking facilities are available. The centre is staffed on a 24/7 basis with a full time person in charge (who is a clinical nurse manager II), a team of staff nurses and health care assistants. Access to GP services and other allied healthcare professionals form part of the service provided to the residents. Transport is also provided for residents for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 22 August 2024	09:10hrs to 15:00hrs	Úna McDermott	Lead
Thursday 22 August 2024	09:10hrs to 15:00hrs	Úna McDermott	Lead
Wednesday 21 August 2024	14:00hrs to 19:00hrs	Mary McCann	Support
Wednesday 21 August 2024	14:00hrs to 19:00hrs	Mary McCann	Support

What residents told us and what inspectors observed

This inspection was an unannounced focused regulatory inspection to review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and the National Standards for Adult Safeguarding (2019). It followed a regulatory notice issued by the Chief Inspector of Social Services in June 2024 in which the safeguarding of residents was outlined as one of the most important responsibilities of a designated centre and fundamental to the provision of high quality care and support. Furthermore, that safeguarding is more than the prevention of abuse, but a holistic approach that promotes people's human rights and empowers them to exercise choice and control over their lives. From what inspectors observed, it was clear that this centre required a consistent leadership presence which would improve compliance and support a holistic safeguarding culture. Improvements were required in governance and management, positive behaviour support, safeguarding, residents' rights, staffing, training and development, risk management and the premises provided.

This inspection took place over two half days. There were nine residents with complex medical conditions and high support needs living in this centre. Inspectors engaged with all residents over the course of the inspection. While residents were unable to verbally express their views, they used other communication methods such as vocalisations, facial expressions and gestures to communicate. Some were observed smiling with staff and the interactions between them were kind, caring and respectful.

The person in charge was on leave during this inspection. Deputising arrangements were in place, however, this person was also on leave. On arrival, there was uncertainty as to who was in charge and who would facilitate the inspection. Shortly thereafter a member of the wider management team confirmed they would facilitate the first afternoon of the inspection. On the second morning, the deputising person in charge and the provider representative were in attendance at the centre.

Residents were observed to have active lives. As it was a dry afternoon, some residents were leaving the centre on the transport provided. Staff said that they liked going out for drives and for walks. Another resident was going to visit a family member. This was a weekly trip which there were reported to enjoy.

Later, the inspectors met two residents in the residents' kitchen. They were supported by an activity co-ordinator who was employed in the centre on weekdays. They were observed preparing ingredients for an apple crumble. Inspectors spoke with the co-ordinator about activities that residents enjoyed. They said that one resident enjoyed singing and was a member of a musical memories group in their local community. They attended a performance recently where they got a hooded sweatshirt in the group colours which they liked very much. The resident smiled

broadly as they listened to the staff member.

The second resident involved in this activity was sitting quietly while moving their hands to their face and mouth. It was noted that they were wearing socks on their hands, which were reported to protect them from scratching their skin when itchy. These were removed during the baking activity and this will be expanded on under regulation 7 below.

Inspectors visited the multi-sensory room where a resident was relaxing. It was had soft lighting and music was playing. A staff member arrived with an afternoon snack for the resident which was nutritious and the consistency was as recommended in by their speech and language therapist (SALT). Other residents were spending time in the large sitting room or resting on their beds.

A walk around of the centre found that while the registered provider continued to enhance the premises provided, it was institutional in design and five residents continued to share sleeping accommodation. In addition, residents required additional aids to support them with personal intimate care tasks such as showering and inspectors saw that there were issues with the space provided for showering. This will be expanded under regulation 17 below.

During the course of the inspection, conversations were held with nine staff members. The purpose of these was to review awareness of the holistic nature of safeguarding and to gather information on how safeguarding practices were promoted in the centre. Staff said that they were provided with human rights training and expressed the view that resident's rights were important. They spoke about being accountable for their work and that it was their duty to ensure that residents were protected from abuse. They said that the care and support in the centre was good, that the food provided was high quality and that residents were provided with a choice of meals. However, when given examples of safeguarding risks such as ignoring a resident or leaving them to wait for attention or support, they did not see this as a possible safeguarding concern. In addition, some staff said that it be difficult to raise a safeguarding issue, as they worried about the impact an investigation may have on staff relationships.

All staff raised concerns about the lack of consistent leadership in the centre. They said that this was confusing, that it impacted on the support and supervision provided to the staff team and that it affected the standard of care provided to residents. In addition, they said that while there were eleven staff on duty that day, that this was not always the case. Staffing levels were reported to fluctuate and there was a high level of absenteeism.

From what the inspector observed and from discussions with staff members, it was clear that residents living here were provided by good quality care by the staff team. The person in charge and the registered provider were aware of the challenges relating to governance and management of the centre and the premises provided. While improvements plans were in place, ongoing work was required to support the staff team and to promote a holistic and person-centred approach to safeguarding and protection

These matters will be expanded on in the next two sections of this report which will outline the findings of this inspection in relation to the governance and arrangements in place in the centre and how these impacted on the quality and safety of the service

Capacity and capability

As outlined, this designated centre was institutional in design and was not suitable for the assessed needs of the residents living there. An additional restrictive condition was attached to the registration of this centre which meant that more appropriate living conditions were required for the residents by 31 December 2025. The registered provider had plans to address this which were ongoing at the time of inspection.

Inspectors found that provider had management systems in place with regard to safeguarding. However, there were ongoing changes to the leadership and management arrangements in the centre. This meant that there was a lack of consistent leadership which impacted on the oversight of the systems used. Improvements were required with governance and management, positive behaviour support, residents' rights, staffing, training and development, risk management and the premises provided. All of which would enhance the safeguarding and protection of residents at the centre.

A review of staffing arrangements found that while the registered provider had plans in place to organise their workforce to reduce the risk of harm, improvements were required. At the time of inspection an appropriate number and skill-mix of staff were employed to support residents. However, staff reported that staffing provision fluctuated and was impacted by a high level of absenteeism on a day-to-day basis. In addition, improvements were required with the maintenance of the roster.

Staff employed had access to training and development opportunities, including modules which promote the rights, health and wellbeing of each resident. A sample of mandatory and refresher training modules found that most were up-to-date. In addition, the provider had planned and requested bespoke training for staff relating to residents individual needs.

Overall, the inspector found that staff employed in the centre had an awareness of safeguarding practices which was supported through a training and development programme. While there were systems in place to underpin the safe delivery and oversight of the service, they were impacted by gaps in the leadership arrangements at the centre. The registered provider had a plan to address this issue which required ongoing attention.

Regulation 15: Staffing

The registered provider worked towards the provision of an appropriate number and skill-mix of staff at this centre in order to meet the safeguarding needs of all residents. This included a large staff team of both nursing and healthcare assistant staff and a rolling roster arrangement was in place.

Staff recruited to work in the service completed an induction programme and were subjected to checks to ensure their suitability for the role. On request, inspectors were provided with a sample of Garda vetting disclosures for 10 staff members. All were up to date.

A review of the roster found that staff were consistently employed and were familiar with residents and their assessed needs. If additional staffing was needed, regular agency staff members were provided.

However, there were challenges with the staffing arrangements and the inspectors found that further work was required. For example,

- There were ongoing changes to the leadership and management arrangements in the centre since 9 November 2022. This meant that there was a lack of consistent leadership in the centre.
- Some staff nurses in the service had additional responsibility for administrative tasks. This included management of the roster and replacement of staff when an unplanned absence occurred, which impacted on their availability to give direct support to residents. This arrangement required review
- A review of the roster found that it lacked organisation and clarity. The deputising arrangement for the person in charge was not recorded on the roster and staff were not always aware of who was in charge. In addition, full names were not always documented and not all changes in duty were recorded accurately.
- Staffing levels fluctuated in the centre. While there was a high staff to resident ratio on the days of inspection, this was not always the case with staff reporting reduced numbers at weekends. In addition, the roster for July 2024 found that while the provider planned to have two nurse on day duty, there were nine occasions when the plan was not effective and one nurse was employed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The registered provider had systems in place to reduce the risk of harm and promote the wellbeing and rights of residents through the provision of training and

supervision. For example,

The provider had a training matrix which outlined a range of mandatory and refresher training courses available for staff. This was under regular review.

Staff were provided with safeguarding training and training in positive behaviour support as part of their induction process. A sample of 75% of the staff team found that these modules were in date.

Staff were provided with on-line training in the promotion of human rights. Staff spoken with had an understanding of how to uphold residents rights and in the main, they were aware of what to do should a safeguarding concern arise.

As part of safeguarding assurances sought in April 2024, the registered provider said that they would complete a training needs analysis at the centre. Although a documented analysis was not available on the day of inspection, there was evidence of a plan to provide additional training in person centred care and support and training in management of gastrostomy feeding.

However,

- Following an incident in March 2024 leading to accidental injury to a resident, all staff were to attend up-to-date manual handling training , however two nurses had still not completed this training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had an understanding of the importance of good governance and effective management and how deficits in oversight could impact safeguarding practices in the centre. For example,

Team meetings were taking place regularly. The minutes for six meeting which were held since January 2024 were provided for review.

The six monthly provider-led audit and the annual review of care and support were up to date. Actions identified were included on a quality improvement plan which was reviewed on 15 August 2024.

In response to adverse incidents occurring at the centre, an additional independent review was commissioned and completed on 22 July 2024. The review team included the regional director of nursing and a member of the quality and patient safety team. Recommendations were made and opportunities for shared learning documented.

However, improvements were required as follows,

- There were ongoing changes to the leadership arrangements at this centre which impacted the quality and safety of the service and the stability of the staff team. The deputising person in charge had other roles of responsibility with the provider. They told inspectors that they attended the centre one day per week or one day per fortnight. Staff spoken said that ongoing change impacted on the morale of the staff team and the quality of the service provided.
- The staffing arrangements required strengthening to ensure that the roster provided an accurate reflection of the staff on duty. In addition, that fluctuations in staffing numbers provided were reviewed.
- The oversight of the documentation systems required review as gaps were identified. These included safeguarding forms that were not accurate, protocols that were not signed or dated, care plans that required updating and risk assessments that required review.
- Although safeguarding and protection practices were in place, due to gaps in governance arrangements, the conclusion of a trust in care investigation was delayed. The investigation commenced in April 2022 and was ongoing at the time of inspection

Judgment: Substantially compliant

Quality and safety

Residents living at this centre had a range of complex high support needs and were at risk of decline in their health and wellbeing. A nurse-led service was provided and a team of healthcare assistants were employed. Inspectors found that while good quality care was provided improvements to the premises provided and the systems used would enhance the safety of the service.

Residents at this centre had active lives both in the centre and in their communities. They had individual assessments and personal plans which involved the resident and their representatives if appropriate. A named nurse system was used and goals were planned, completed and documented. However, improvements were required to ensure that information provided was clear and up to date. This is reported on under regulation 23.

Residents that required support with behaviours that challenged had access to specialists in behaviour management and written plans were in place. If required, these plans included strategies to protect residents from harm while safeguarding others present. Restrictive practices were used in this centre, however not all had

protocols in place and this required review.

A review of safeguarding systems used found that while the provider had processes in place, and staff were aware of what to do, the practices required review. This included the updating of information regarding designated officer, the review of safeguarding information held at the centre to ensure that it was readily available and actions taken were clearly and correctly documented. In addition, where investigations were required that they were completed in a timely fashion as the provider representative told inspectors that changes in the management team meant that progress of an investigation was delayed. This required review.

A review of incidents occurring found that not all actions recommended were completed in line with timelines provided. During a four month period, five adverse incidents occurred which included accidental removal of feeding tubes and bone fractures. Following these, residents required treatment for at their general practitioner (GP) or at hospital. Inspectors found evidence that a nurse specialist made recommendations on bone health which were completed and a seating specialist ensured that residents' wheelchairs were checked and upgraded if required. However, the support of an occupational therapist was not provided as the registered provided reported that the post was vacant at that time. This required review.

The registered provider and the staff team were aware that additional measures were required in order to ensure that residents' rights were respected, protected and exercised in order to underpin a positive safeguarding culture. A range of visual and easy-to-read communication tools were available and staff were provided training in human rights and decision making. However, due to the institutional design of the premises five residents shared sleeping accommodation. In addition, the completion of intimate care tasks required review to ensure that they were completed with due attention to residents dignity and right to privacy.

The provider was aware of that residents were at risk of decline due to their medical diagnosis and that every action practicable was required to prevent risks occurring or reoccurring. Inspectors found that there were some good risk management practices at this centre, while others required improvement. This included a review of risk assessments and falls screenings to ensure that they were in line with the provider's policy and a review of control measures to ensure that they were completed as recommended.

Regulation 10: Communication

The registered provider and the staff team were aware that the ability to communicate effectively was fundamental to each residents' wellbeing, social relationships and quality of life. Inspector found that residents were supported to express their needs where possible and interactions between staff and residents were observed to be kind and respectful. For example,

Staff employed at this designated centre were consistently employed, and familiar with the residents and their individual communication styles.

Residents had access to the support of a speech and language therapist. Their communication needs and supportive tools such as communication dictionaries were in place as recommended and available in their personal plans. Staff were proactive in observing the effectiveness of the recommended strategies and where additional support was required a plan was in place for this.

Staff were aware of the role of advocacy and there was evidence that they acted when required. For example, when in hospital, staff attended in order to ensure that the voice of the resident was heard and their needs acknowledged. Where there was uncertainty of behalf of hospital staff, evidence of follow up was provided, to ensure that the care provided was in line with the residents assessed needs.

Judgment: Compliant

Regulation 17: Premises

As outlined above, this service was provided in an institutional setting. The registered provider had a de-congregation plan which was ongoing at the time of inspection and had specific time-lines attached for its completion.

While the provider had improved areas of the building, it remained unsuitable.

- Five residents shared multi-occupancy dormitories and cubicles were provided for their beds and personal belongings.
- Access to showering facilities required review. Inspectors found that a resident was required to undress in the dormitory and then travel across the corridor on a showering trolley to the shower room. Although privacy screens were provided this was not a suitable arrangement. Furthermore, in order to access the shower room, the shower trolley was wheeled into another resident's bedroom to gain sufficient turning space.

Judgment: Not compliant

Regulation 26: Risk management procedures

Inspectors found that five incidents were reported to the Chief Inspector of Social Services that occurred over a four month period (March to June 2024) at this centre. Four of these resulted in an injury that required attention at hospital. Some residents were at risk of decline due to their medical diagnosis and this was documented. However, this meant that every action practicable would be taken to prevent their occurrence. Inspectors found that there were some good risk

management practices at this centre, while others required improvement.

The registered provider had an up to date risk management policy

Residents had individual risk assessments and a sample of those reviewed were up to date included risk of choking, risk of skin breakdown, risk of fracture and risks relating to the management of residents feeding tubes.

In relation to risk relating to accidental removal of feeding tubes, a review of the control measures in place found that they were completed. Staff were trained in feeding tube re-insertion and from conversations held with staff, it was clear that daily and weekly checks documented were taking place.

Service level risk assessments included risks relating to the absence of a substantive person in charge at the centre and risk relating to lack of access to an occupational therapist.

However,

- Following an incident in March 2024 leading to accidental injury to a resident, all staff were to attend up-to-date manual handling training , however two nurses had still not completed this requirement.
- In addition, this resident had documentation on file relating to the risk of falling. However, their falls screening assessment was incomplete and their risk assessment and bone health screening tool was not updated since September 2023 even though the resident had sustained a fracture since this date and it therefore required review.
- A handling plan completed by the providers National Health and Safety function was completed in April 2023. Although, it included some special considerations for the completion of handling tasks, it was out of date and did not include risk of fractures or risks relating to feeding tubes which were relevant to the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The registered provider had systems in place to ensure that individual assessments and person plans were completed, that they reduced the risk of harm and promoted the health and wellbeing of each resident. For example,

Where possible, residents and their representatives were involved in decisions about their care and support, however, due to the residents assessed needs this was not always the case.

Residents were observed to have active lives and a review of documentation found that they had goals planned. These included trips to musical events, markets,

pamper days and day trips. Activities were reviewed regularly, the outcome was recorded and photographs were included.

However, improvements were required with some documentation to ensure that information provided was up to date and that signposted to supporting documents was provided if required. This is reported on under regulation 23.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents that required support with behaviours that challenged had access to specialists in behaviour management and written plans were in place. If required, these plans included strategies to protect residents from harm while safeguarding others present. For example,

A review of a resident's behaviour support plan found that it was reviewed on 2 April 2024. The plan included the recommendations of other members of the multi-disciplinary team and therefore was integrated in approach. Proactive strategies included the use of visual communication tools as recommended by the speech and language therapist. Inspectors saw cards with images on them and objects to use for reference in the sitting room. These were used to support the resident's understanding and to avoid adverse incidents.

The registered provider was aware of the impact of behavioural escalations on others and residents requiring a high level of support had a 1:1 staff ratio in place. These staff members were training in positive behaviour support and were familiar with the resident as recommended by the positive behaviour support plan.

The provider was working towards a restraint-free environment and a door lock on a kitchen which was removed following a previous inspections remained unlocked. This meant that it was sustained and there was evidence of this space being enjoyed by the residents for a baking activity as outlined above.

There was evidence that staff employed were aware of the requirement to balance the rights of residents to live as independently as possible while ensuring that they were kept safe. A staff member raised a concern relating to a restrictive practice in December 2023 which was documented and addressed by the registered provider. Other restrictive practices relating to necessary medical interventions had protocols in place which were subject to regular review.

However, while inspectors found that work on a restraint free environment was ongoing, some practices required review as follows,

- A resident was observed with socks on their hands. Staff spoken with told inspectors that this was to protect them from breaking their skin when scratching and that the resident would put the socks on themselves at times.

However, no protocol was in place to provide a rationale for the socks use and to guide staff and therefore this required review.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had systems in place to promote a holistic and person-centred approach to safeguarding. The quality and effectiveness of these systems were of particular importance at this centre as the residents living here did not communicate verbally and due to their assessed needs had limited ability to develop self-awareness or self-protection skills. Inspectors found some good practices at this centre, as follows,

The registered provider had a safeguarding policy which was up to date and displayed on the staff notice board.

Staff had access to training in relation to safeguarding residents and the prevention, detection and response to abuse. A sample of staff training reviewed found that these modules were up-to-date.

From conversations held and from documents reviewed, staff had an awareness of the types of abuse, that they were accountable for the delivery of care and that they were required to act if required. The person in charge was completing awareness audits with staff and there was evidence of staff taking a proactive approach if they identified a possible safeguarding concern. This included the reporting of incidents in January 2022 and December 2023.

However, further work was required in order to meet with the requirements of local and national safeguarding policy and guidelines. For example,

- The registered provider had identified and trained three designated officers and their pictures were displayed on the staff notice board. However, two of the three officers were not working at the centre and the information sheet had not been updated.
- The quality of safeguarding processes required review. Inspectors found that information was not readily available and there was a lack of clarity relating to the purpose of documentation, the location of safeguarding plans and the regular review of the actions agreed. In addition, a review of a safeguarding screening form dated 6 January 2022 found the name of another resident that did not live at the centre was incorrectly documented on form.
- The investigation of incidents occurring at the centre required review. An incident which was reported to the registered provider in January 2022 had an investigation initiated in April 2022 which was not fully concluded at the time of inspection.
- While there was evidence that staff took safeguarding concerns seriously and

took appropriate action if required, work was required to promote a culture of openness, accountability and support among the staff team and to provide assurances that adverse incidents and allegations will be addressed promptly and learning used to inform future practice.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The residents living at this designated centre had a range of complex medical and high support needs. The registered provider and the staff team were aware that enhanced measures were required in order to ensure that residents' rights were respected, protected and exercised and how this would underpin a positive safeguarding culture. Inspectors found good examples of human rights promotions and other areas where improvements were required. For example,

A range of visual and easy-to-read communication tools were available for residents. These included the statement of purpose for the centre and the complaints policy. In addition, the registered provider was attentive to the principles of consent and residents had consent recording forms on their files which signposted the reader to communication recommendations to support the consent process.

Staff were provided with training in human rights and the Assisted Decision-Making (Capacity) Act 2015. Guidance on the contact details for the national advocacy service and the confidential recipient were displayed.

Staff spoken with told the inspector about providing residents with choice. They said that a resident required support to transfer from their bed to their wheelchair. They show the resident the standing aid and ask them if they would like to use it. The resident will then use expressions to let the staff know their preference. A review of supporting documentation found that this choice was clearly documented in their seating assessment completed on 8 April 2024.

However, as outlined at the outset, the premises provided was institutional in design. This meant that five residents had dormitory style sleeping arrangements. While the provider was working towards a resolution, the design of the building continued to impact on the rights of residents. This will be addressed under regulation 17.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for James Connolly Memorial Residential Unit OSV-0002502

Inspection ID: MON-0044635

Date of inspection: 22/08/2024

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: To ensure compliance with Regulation 15: Staffing the following actions have been/will be undertaken. • In the absence of the PIC the DON and the /ADON Letterkenny Network has been providing ongoing support to the centre. This arrangement has been discussed at the local governance meeting on the 20th June 2024. Completion date: 20-06-2024 • The centres roster will be updated to include that the DON/ADON will be provided support to the centre on the absence of the PIC and contact details for the DON/ADON will be added to the roster. Completion date: 07-10-2024 • From the week commencing the 28th October 2024 the ADON for the Inishowen service will be based at the JCM to provide ongoing support to the centre in the absence of the PIC. The ADON will have responsibility for the completion of the centres roster. Completion date: 28th October 2024 • Documentation has been completed for the replacement of the CNM2/PIC in JCM and is currently awaiting approval. Completion date: 04-10-2024 • The ADON will complete a review of the roster to ensure adequate staffing in the centre on a daily basis to meet the assessed needs of the residents. Completion date: 07.10.2024	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with Regulation 16: Training and staff development the following actions have been/ will be undertaken.	

• One staff attended manual handling training on the 29-09-2024 and the second staff is scheduled to attend manual handling training on the 10-10-2024. Completion date: 10-10-2024.

• The DON/ADON will complete a training needs analysis for the centre to ensure all staff complete mandatory and site specific training. A copy of the individual training requirements will be given to each staff member. Completion date: 31-10-2024.

• The ADON has developed a schedule for the completion of performance achievement meetings with all staff in the centre. Completion date: 31-12-2024

• The ADON will add the training needs to the centres QIP and review same on a weekly basis. Completion date: 31-10-2024

• The ADON will continue to monitor the centres training matrix to ensure all training is completed within the agreed timeframe. Completion date: ongoing.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

To ensure compliance with Regulation 23: Governance and management the following actions have been/ will be undertaken.

• In the absence of the PIC the DON/ADON Letterkenny Network has been providing ongoing support to the centre. This arrangement has been discussed at the local governance meeting on the 20th June 2024. Completion date: 20-06-2024.

• The centres roster will be updated to include that the DON/ADON will be provided support to the centre on the absence of the PIC and contact details for the DON/ADON will be added to the roster. Completion date: 07-10-2024.

• From the week commencing the 28th October 2024 the ADON for the Inishowen service will be based at the JCM to provide ongoing support to the centre in the absence of the PIC. The ADON will have responsibility for the completion of the centres roster. Completion date: 28th October 2024

• Documentation has been completed for the replacement of the CNM2/PIC in JCM and this is currently awaiting approval from the Regional Executive Officer. Completion date: 31-12-2024

• The ADON will complete a review of the roster to ensure adequate staffing in the centre on a daily basis to meet the assessed needs of the residents. Completion date: 07.10.2024

• The DON/ADON will complete a review of the safeguarding process to ensure all information pertaining to the safeguarding process is readily available to include location

of safeguarding plans and ensure regular review of the safeguarding plans. Completion date: 31-10-2024

• The DON/ADON will review all protocols in the centre to ensure they are all signed and dated. Completion date 31-10-2024

• The DON/ADON in conjunction with the named nurses will review all care plans and risk assessments to ensure all documentation is up to date and is reflective of the assessed needs of the residents. Completion date: 30-11-2024

• The Disability Manager has received the report from a Trust in Care Investigation which commenced in April 2022. The report completed by the National Investigation unit has not made any recommendations in relation to the TIC. The finalized report has been submitted to the Head of Service for escalation to the Chief Officer for review.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

To ensure compliance with Regulation 17: Premises the following action will be undertaken.

• There is a de-congregation plan in place for the 9 residents residing in the JCM. The timeframe for the completion of de-congregation plan is Q4 2025.

• The Occupational Therapist has scheduled a visit to the centre on the 07-10-2024 to review the current showering facilities. Completion date: 31-10-2024

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

To ensure compliance with Regulation 26: Risk management procedures the following actions have been/ will be undertaken.

• One staff attended manual handling training on the 29-09-2024 and the second staff is scheduled to attend manual handling training on the 10-10-2024. Completion date: 10-10-2024.

• The DON/ADON is conjunction with the named nurse will ensure the Falls Risk Assessment for one resident will be completed in its entirety. Completion date: 31-10-2024

• The DON/ADON is conjunction with the named nurse will review and update the risk assessment on bone health and the bone screening tool for one resident. Completion date: 15-11-2024

• A Manual handling plan dated April 2022 will be reviewed and updated by the DON/ADON to ensure it reflects the risk of fractures and the risk associated with feeding tubes. Completion date: 31-10-2024

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

To ensure compliance with Regulation 7: Positive behavioural support the following actions will be undertaken.

• The DON/ADON has liaised with the psychological and has scheduled a meeting on the 07-10-2024 to

1. To ensure the least restrictive practice is utilized and a risk assessment completed for the sock use.

2. To provide a rationale for the sock use and provide guidance to staff. Completion date: 31-10-2024

• The DON/ADON will ensure the restrictive practice is recorded in the restrictive practice log. Completion date: 30-10-2024

• The DON/ADON will ensure this restrictive practice is reported to the regulator in the quarterly notifications. Completion date: 31-10-2024

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

To ensure compliance with Regulation 8: Protection the following actions will be undertaken.

• The DON/ADON has updated the name and contact details of current designated officers for the centre. Completion date: 04-10-2024

• The DON/ADON will complete a review of the safeguarding screening dated 6th January 2022 to ensure the correct details of the resident is documented on the safeguarding screening. Completion date: 08-10-2024

• The DON/ADON will complete a review of the safeguarding process to ensure all information pertaining to the safeguarding process is readily available to include location of safeguarding plans ensure regular review of the safeguarding plans. Completion date: 30-11-2024

• A review of incidents occurring in the centre will be completed by the DON/ADON to ensure all actions arising from the safeguarding plans have been completed and where further investigation were warranted this has been completed. Completion date: 30-11-2024

• The DON/ADON will continue to complete the safeguarding questionnaires with staff on

a monthly basis as per the centres audit schedule to ensure staff continue to have adequate knowledge of the safeguarding process. Completion date: Monthly

• Safeguarding is on the agenda for all local governance meetings which provides staff an opportunity to discuss any concerns thus creating a culture of openness and transparency. Completion date: Bi monthly

• The DON/ADON will ensure that any learning from adverse events will be discussed at the centres local governance meetings and the learning will be used to inform future practice.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/11/2024
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	30/11/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	31/12/2024

	as part of a continuous professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2025
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	30/11/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	15/11/2024
Regulation 07(3)	The registered provider shall ensure that where required,	Substantially Compliant	Yellow	30/11/2024

	therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/11/2024