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:	Dunwiley
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	07 September 2022
Centre ID:	OSV-0005489
Fieldwork ID:	MON-0036787

About the designated centre

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

Dunwiley designated centre is located within a small campus setting which contains six other designated centres operated by the provider. Dunwiley can provide full-time residential care and support to up to five male and female adults. The designated centre comprises of a six bed bungalow. 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 are buses available for residents to access the community if they wish. Residents are supported by a staff team of both nurses and care assistants. During the day, support is provided by four staff. At night residents are supported by two staff members. Nursing care is provided on a 24/7, basis meaning a nurse is allocated during the day and at night. The person in charge is responsible for one other designated centre and is supported by a clinic nurse manager 1 to ensure effective oversight of the services being provided.

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
Wednesday 7 September 2022	13:50hrs to 18:30hrs	Angela McCormack	Lead
Thursday 8 September 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 are now completing a programme of inspections to verify whether these actions have been implemented as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Donegal.

At the time of the inspection the provider had implemented a number of actions to strengthen 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. However, it was found on this inspection that improvements were required in the adherence to procedures for protection of residents and for recording and reviewing restrictive practices following behaviours of risk. These will be discussed in the other sections of the report.

There were three residents living in Dunwiley at the time of inspection. There were no plans for any resident to move into Dunwiley, and the inspector was informed that an application to vary conditions of registration was in progress to be submitted to reduce bed numbers and to change the primary functions of some rooms. The inspector got the opportunity to meet with all three residents over the course of the inspection. Residents interacted with the inspector on their own terms and with the support of staff. One resident chose to spend time speaking with the inspector alone.

Residents were observed coming and going to various activities and outings throughout the inspection. Staff members spoken with described about how the environment in the house had changed since the numbers living there had reduced and that residents appeared more relaxed. One staff member spoke about how things were going well and about how they felt that this living arrangement suited residents now. One resident spoken with said that they were happy in the centre and when asked, they said that they felt safe.

One resident had resumed attending their day service on a full-time basis that week, and they appeared happy about this. Two residents were supported to do activities of choice from their home and there was a visual time-table of scheduled activities on display on the wall of the hallway. Activities included; swimming in a local hotel, going to the gym, shopping trips, aqua aerobics and included attending classes/activities at the nearby day service hub, as and when activities of interest to residents were planned. The inspector was also informed about how some residents helped out with their family member's business and enjoyed this. Residents were reported to have good communication and contact with their families, with one resident going to stay with family each weekend.

On the days of inspection, residents were attending their day service, going out for coffee, going out on the bus, visiting family and going swimming. One resident greeted the inspector on arrival to the centre, and spoke about things that they liked doing and plans that they had for the day. Another resident briefly interacted with the inspector also and led the inspector to the sitting-room where they appeared to want to show the room. Residents were supported by staff in line with their assessed needs and staffing requirements throughout the inspection. Staff were observed to be caring and respectful in their interactions with residents, and were observed responding to residents in a prompt and warm manner.

Residents had enjoyed breaks away and day trips throughout the Summer. Two residents had been supported to go abroad on holidays, and one resident spoke briefly about this and said that they enjoyed it. Through a review of documentation and discussions with staff and residents, it was evident that residents were supported to enjoy a range of activities of choice and to set meaningful goals for the future. These included; going on holidays, going on day trips to religious locations and cities, getting a laptop and attending day services on a full-time basis.

The house appeared homely, clean and spacious for the needs and numbers of residents. The house was decorated with artwork, photographs and colourful soft furnishings. There was a visual activities schedule in place, and a visual photograph roster on display in the hallway, which was accessible to residents. One resident was observed asking a staff member about who was on duty that night, and they were observed to look at the roster. There were notice boards with information for residents including easy-to-read information about various topics, including making complaints and staying safe on social media.

There was a large back garden area out the back, which was accessible through double doors leading from three communal rooms. There were potted plants observed around the house and the garden was spacious and contained garden furniture for residents to sit out and enjoy if they chose to. In addition, there were raised beds and planters in the garden and the inspector was informed that some residents enjoyed gardening and were supported to grow vegetables. In addition, there was a bench out the front of the house, on which a resident was observed sitting during the inspection, and they appeared to enjoy watching and interacting with people coming and going to the house.

The house was spacious for three residents. Each resident had their own bedroom and some bedrooms had en-suite facilities. The communal bathrooms were large with level access showers, and one bathroom had a Jacuzzi bath also. There was a large living room which was beautifully decorated with a feature wall and soft furnishings and contained comfortable furniture and a television. There was a separate utility area which stored laundry equipment, and which was accessible through the hallway. There was a dining room which had two sets of tables and chairs, and this was where meals were eaten. Residents' main meals were delivered from a centralised kitchen on the campus, and it was observed that dinner/lunch was delivered at 12.30 on the second day of inspection. The kitchen was small and contained some cooking equipment, cupboards and a fridge to store food items. The cupboards and fridge freezer were noted to be stocked with food items and snacks.

One resident showed the inspector their bedroom. It was observed to be personalised with photographs and personal items. A vacant bedroom was being used as a third sitting-room and was located opposite the resident's bedroom. This room had a couch and television and staff reported that each resident had use of an individual sitting-room now if they chose to use. This supported measures to reduce potential safeguarding concerns between residents and allowed each resident personal space within their home.

As noted in previous inspections reports, there were some safeguarding concerns and incompatibilities between residents living in Dunwiley. Safeguarding concerns and incidents had reduced with the reduced numbers living in the centre. Environmental measures and staffing numbers also helped to reduce and minimise potential risks. The inspector was informed, and it was noted in a safeguarding document, that it was being followed up to get sound proofing in one resident's bedroom to reduce any possible impact on them from the behaviours of concern displayed by another. This action was in progress at the time of inspection. While measures were in place to try to reduce safeguarding concerns between residents, the inspector found that the safeguarding procedure had not been followed for all concerns raised. This will be discussed in the next sections of the report.

In general, the inspector found that the service strived to provide a good quality and person-centred service to residents. However, improvements in consistently adhering to the policies and procedures in place to protect residents, would further support a safe and quality service. The following sections of the report outline the governance and management and how this impacts on the quality and safety of care provided to residents.

Capacity and capability

This inspection was a follow up inspection to review actions required as identified in an inspection in February 2022 and to review actions identified by the provider as part of the overview report, as mentioned previously. An update to the compliance plan of the overview report had been requested and received by the Chief Inspector of Social Services in July 2022, and it was noted that most actions had been completed, or were in the process of being completed. In addition, the provider was required to submit monthly updates on a management improvement plan for the overall campus to the Chief Inspector since April 2021. Progress on some of these actions were also reviewed on this inspection.

During this inspection, improvements were found in the overall governance and management and in the systems in place for auditing and oversight. However, further improvements were required. These related to; ensuring that all actions identified through inspections were completed, that all notifications were submitted to the Chief Inspector and in ensuring that procedures in place for the protection of residents were followed consistently. These will be discussed throughout the report.

The management structure consisted of a person in charge who reported to the director of nursing (DON). There was a clinical nurse manager 1 (CNM1) to support the person in charge with the operational management of the centre. The CNM1 was available on the first day of the inspection, and the person in charge was available on the second day. Both the person in charge and the CNM1 had responsibility for Dunwiley and one other designated centre which was also located on the campus. The CNM1 supported the person in charge with completing audits, oversight of systems and staffing.

Staffing arrangements were reviewed as part of the inspection. The skill mix included nursing staff and healthcare assistants. There was a planned and actual rota in place which showed that there was the numbers of staff working to meet the needs of residents. Some agency staff were used to fill staffing gaps, however this was kept to a minimum and the centre had a cohort of regular agency staff to ensure continuity of care. In general, consistent staff and the appropriate numbers of staff were available. Staff were observed supporting residents in line with their needs, and they appeared familiar to residents and residents appeared comfortable around staff.

A staff training matrix was maintained which included details about when staff had completed training. A sample of training records reviewed demonstrated that in general, staff members had competed the mandatory and refresher training as required. One agency staff was due training in Sexuality Awareness in Supported Settings (SASS), and this was scheduled for the coming days. One staff nurse was due training in cardiopulmonary resuscitation (CPR), and a date had yet to be set for this. There were two separate training matrices for both permanent and agency staff. However, it was found that two agency staff who worked in the centre on the days of inspection were not included on the matrix. This had been an action identified in the last inspection, and had not yet been fully completed. While some training certificate records were made available by the end of the inspection, this action for ensuring oversight of training for all staff supporting residents had not been completed and required further review.

There were a number of management audits being completed in the centre which demonstrated that there were arrangements for oversight and ongoing monitoring of the centre by the local management team and the provider. A new schedule of audits had recently been implemented in the centre. This was part of the provider’s actions from the overview report. This included audits in safeguarding, incidents, complaints, medicines, fire safety, finances, health and safety, restrictive practices and the use of physical interventions. The schedule detailed that these audits were to be completed at set intervals during the year, such as monthly, quarterly or bi-annually. A sample of audits reviewed demonstrated that the local management team had commenced these audits in line with the revised schedule.

The provider had implemented a number of governance meetings as part of their action plan from the overview report to strengthen the oversight and management systems. A sample of meeting minutes were reviewed on the inspection including; the local governance meetings (held bi-monthly), county level person in charge meetings (held fortnightly), human rights committee (held quarterly) and quality, risk and patient safety group (held quarterly). The person in charge meeting minutes reviewed demonstrated that shared learning occurred, for example in infection prevention and control (IPC) measures. the last meeting notes reflected a discussion on 'consent' and identified a training need in the application of the 'consent policy'. In addition, the inspector got the opportunity to speak with a member of the human rights committee who spoke about their work to date and about plans for the committee to evolve in further promoting the rights of residents. The person in charge spoke about their involvement in the 'policy, procedure, protocol guidelines development group' and spoke about a recent review of the restrictive practices policy and procedure to incorporate more information around consent. The inspector was informed about how this policy would also help to inform the human rights committee work.

While improvements were noted with regard to the oversight of actions identified in audits and in the reviews of incidents, further improvements were required as they failed to pick up some actions for improvement as found on inspection. This included the non-adherence to the safeguarding policy for one incident, the omission to send some notifications to the Chief Inspector and the lack of adherence to the procedures for restrictive practices to make sure the relevant information was recorded on the recording forms.

The provider ensured that unannounced six monthly audits were completed. There was one completed in April 2022, which identified a number of areas for improvement. These were either completed or in progress. The centre had a quality improvement plan (QIP) which contain all actions arising from the provider audits, inspections by the Health Information and Quality Authority (HIQA) and a self-assessment audit by the person in charge. The person in charge showed the inspector the most up-to-date QIP and spoke about actions completed and some that were in progress, including an application to vary conditions of the registration of the centre relating to bed numbers and room functions.

A review of incidents and practices in the centre indicated that the person in charge had submitted most of the notifications as required in the regulations for the Chief Inspector. However, not all had been submitted. This included one suspected safeguarding allegation that was recorded on an incident report form, and one incident of minor injury relating to bruising.

The complaints process and record of complaints were reviewed. It was found that complaints were taken seriously and where residents expressed dissatisfaction about aspects of their home; including meals, heating etc, that these were recorded and followed up in line with the complaints procedures and addressed to the satisfaction of the complainant.

Overall, the inspector found the management arrangements had been strengthened in the centre which led to improved outcomes for residents' quality of life and care provided. However, further improvements were required to ensure full compliance with the regulations and in ensuring that the policies and procedures in place to ensure residents' safety were followed and understood by all.

Regulation 15: Staffing

There appeared to be the numbers and skill mix of staff for the needs of residents. While agency staff was used to cover gaps, this was kept to a minimum and cover was provided by a cohort of consistent agency staff. The roster was well maintained and accurate as to who was working on the days of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There were gaps in the records maintained for some agency staff. While a training matrix and relevant records for agency staff had been implemented since the last inspection, it was found that two staff working during the times of inspection were not included on this. This required review to ensure that systems were in place to ensure that all staff working with residents had the required training.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme in January 2022, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO1. The inspector did not review all meeting minutes at this time; however the provider had through it's update to the Chief Inspector in July 2022, stated that all meetings and committees were in place. Seven actions were reviewed on inspection, including a review of the minutes of four governance meetings/committees, namely the staff governance meetings, person in charge meetings, 'human rights' committee meetings and the 'quality, risk and patient safety' committee meetings. Minutes demonstrated that some shared learning, reviews of training needs, staffing and reviews of incidents in centres were occurring. A committee member from the 'human rights committee' also spoke about the work of the committee to date. The person in charge spoke about their participation at the 'policy, procedure, protocol, guidelines and development group' and spoke about having had an individual meeting with the DON the previous week. The action relating to the development of a new audit system was reviewed and completed. This was implemented in Dunwiley on 19 August, and records demonstrated that the local management team had begun to carry out audits based on the revised audit schedule.

However, improvements were required to ensure that the service provided in Dunwiley designated centre was effectively monitored to ensure that the protection of residents was promoted at all times. Improvements were required in the following areas:

- To ensure that all actions identified in previous inspection reports were completed. For example, an action regarding training records and oversight systems for all staff working in the centre had not been fully completed.
- To ensure that the procedures in place to protect residents were consistently followed and to ensure that all persons responsible for the safeguarding of vulnerable adults understood their responsibilities in line with the procedures in place.
- To ensure that all notifications were submitted to the Chief Inspector as required and that the audits in place effectively identified if this was not occurring.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

One notification about an alleged suspected abuse was not submitted to the Chief Inspector as it was not identified as a suspected safeguarding concern. One incident of bruising was not included on the relevant quarterly notification.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints procedure in place which included details about the appeals process. Complaints were kept under review and a review of the records demonstrated that residents were facilitated to log complaints, and that complaints were responded to in line with the procedures in place.

Judgment: Compliant

Quality and safety

Overall the inspector found that residents were supported with their needs and were provided with care that promoted their health and wellbeing. However, the procedures for safeguarding vulnerable adults and the records to be maintained for physical interventions used on residents had not been consistently applied in line with the organisation's policies and procedures. This required review to ensure a quality and safe service at all times.

Residents were found to have comprehensive assessments completed of their health, personal and social needs. This assessment led to a range of care and support plans being developed to guide staff in the supports required. Annual review meetings occurred, which included consultation with residents and their family representatives where relevant. Residents were supported to identify personal goals for the future. Some of these goals included; going on holidays and visiting various cities in Ireland. Goals were found to be kept under review for progress, and residents had a person-centred plan folder, which contained photos of goals achieved.

The inspector found that residents' general welfare and development were promoted. Residents had opportunities for occupation and recreation in their home and were supported to engage in meaningful activities in the wider community. One resident attended a day service, which had been increased to a full-time service the week of inspection. They expressed that they enjoyed this, and were observed singing songs while leaving the centre to go to their day service on one day of the inspection. Other residents took part in activities of choice that supported their general welfare such as swimming in a local hotel, aqua aerobics classes, going to the gym and helping out with a family members business.

Residents' healthcare needs were found to be well supported. There were comprehensive care plans in place where healthcare needs had been identified. Residents were facilitated to access a variety of allied healthcare professionals as required and recommended. In addition, residents were supported to access national screening programmes and had been referred for specialist reviews as required. In addition, each resident had a 'Hospital Passport', which was a document outlining all relevant information required should the resident be admitted to hospital.

Overall, there were good systems in place for risk management. There was a policy and procedure for risk management in place and a safety statement document which outlined emergency plans for the centre. A risk register was maintained and where risks were required to be escalated to senior management, this had been done. However, some aspects of the risk management documentation required review. For example, some risk ratings and names of the centre were inaccurate on some documents. In addition, some risks relating to behaviours of concern displayed on transport required review to ensure that this was appropriately assessed and the relevant risk assessment updated.

Residents that required supports with behaviours of concern had care plans in place. Some of these were under review at the time of inspection and required updating. The inspector was informed that they required the review and sign off by a member of the multidisciplinary team (MDT) prior to them being completed. This was overdue, however the risk of this not being completed in a timely manner due to the competing demands on the MDT team had been escalated by the local management team to senior management. However, there was no evidence of a response or indication about when this risk might be addressed.

The local management team spoke about how some recent behaviour incidents that occurred were under review. The inspector was informed about how the clinical nurse specialist (CNS) for behaviours of concern was currently reviewing a resident due to some new behaviours of concern. They spoke about how a restrictive practice may need to be considered to ensure the resident’s safety while on transport.

A review of incidents that occurred in the centre found that a physical intervention was required at times for use on two individuals due to risks associated with some behaviours. This was included on residents' care plans. The policy and procedure for restrictive practices outlined the requirement to use specific recording forms following use of such interventions. These forms allowed for a record of information about the criteria that determined it's use and also to record the debriefing meeting that occurred with the staff involved. It was found that the relevant records were not completed consistently for each incident of the physical intervention. While there was a regular review undertaken of incidents that occurred in the centre and evidence of oversight by the DON, the use of the correct forms would ensure that the procedures were followed at all times and that clear details about what led to the use of the restrictive practice were recorded for each incident. For example; some forms used were not the correct form detailed in the procedures and they ticked that the physical intervention was used due to a 'medical' or 'health need', however this was not in line with the description of the incident. This did not allow for a robust review and assurances that the practices were used for the identified behavioural risks as detailed on the residents' care plans.

While measures were in place to help to reduce the likelihood of safeguarding concerns between residents, such as environmental strategies, redirection and staffing numbers, it was found that the safeguarding procedure was not always followed when concerns were raised. On review of the incidents that occurred, the inspector found that a recent safeguarding concern had been recorded on an incident form by staff members. This incident record noted that a safeguarding referral had been completed. However, it was found that the safeguarding procedure had not been followed with regard to the concern raised and a preliminary screening form had not been completed. The person in charge informed the inspector about how they spoke with staff who witnessed this incident and said that they discussed this with one of the designated officers of the campus whereby it was then decided that this was not a safeguarding incident. However, these actions were not documented nor had the safeguarding procedures been followed to establish if there was a concern or not. This was a concern, as two previous incidents that occurred in the centre for which preliminary screenings had been completed by the person in charge and designated officer, had found no grounds for concern. However when the safeguarding and protection team subsequently reviewed them, they did not agree with the outcome and safeguarding plans were required. It was also found that one of these safeguarding plans was not accessible in the centre, and this was printed off on the day of inspection. In addition, the review dates and named co-ordinator of the plans required review to ensure that they were reviewed in line with the time-frames and that the named person responsible for co-ordinating the plan was accurate.

In summary, residents were found to be supported with their needs and overall wellbeing. However, improvements were required in some aspects of risk management, in ensuring that the procedures for the protection of residents and for the review of physical interventions were adhered to at all times, which would further ensure a safe and quality service at all times.

Regulation 13: General welfare and development

The provider ensured that residents were supported to participate in activities that were meaningful to them, and in accordance with their wishes and interests. Residents had opportunities for recreation and occupation in their home and in the wider community in line with their preferences and individual needs.

Judgment: Compliant

Regulation 26: Risk management procedures

Some aspects of risk management documentation required improvements:

- Some risk ratings were not reflective of the actual likelihood of incidents occurring
- Some risk assessments contained incorrect information about residents and their location
- One behavioural risk identified through recent incidents that occurred on transport, had not been included on the risk assessment regarding transport.
- There was no evidence of a response to a high risk that had been escalated by the person in charge to senior management

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had comprehensive assessments of needs completed to assess, health, personal and social care needs. Care and support plans were developed where the need was assessed, and these were kept under regular review. Residents were supported to identify personal goals for the future through annual review meetings which included participation of residents and their family representatives.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health and wellbeing. Where healthcare was recommended and required, residents were facilitated to access healthcare appointments. This included national screening programmes and access to vaccinations, as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements relating to positive behavioural support at the centre. One action related to the approval of MDT supports, three actions related to staff training and ensuring staff have knowledge about behaviour support plans and three actions related to the induction of new staff. Not all actions were reviewed on this inspection. However, two actions relating to staff training and ensuring staff knowledge about behaviour support plans were reviewed and found to be completed. However, improvements were found to be required in the documenting and review of physical interventions used by staff in response to behaviours of risk.

Residents had behaviour support plans in place and these were under review with the CNS behaviour therapist and staff team at the time, until the plan was formally updated by all relevant members of the MDT.

A log of restrictive practices was maintained. However, the recording forms and debriefing records were not consistently completed for incidents of physical interventions by staff that were required for behaviours of risk. This was not in line with the organisation's policy and procedure on the use of restrictive practices. While the person in charge spoke about how these incidents were reviewed and about how debriefing was done, the relevant records as required under the organisation's procedures were not consistently completed, which at times led to conflicting information about why the restrictive practice was used.

Judgment: Substantially 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. Not all actions were reviewed on this inspection; however the provider through it's update on the compliance plan of the overview report to the Chief Inspector in July 2022, indicated that all actions were either completed or in progress. One action related to the role of the designated officer and the implementation of a peer support structure for designated officers was reviewed on this inspection. The person in charge had not yet completed 'designated officer' training; however they spoke about the designated officer arrangements for Dunwiley which consisted of three designated officers assigned to the campus, one of which they described as being the main person that they would report concerns to, and that the others were available if that person was on leave.

On this inspection it was found that the arrangements for safeguarding required improvements. While in general residents were kept safe through environmental factors and staffing numbers, improvements were required to ensure that the procedures for safeguarding vulnerable adults were followed when concerns were raised;

- The safeguarding procedure had not been followed with regard to one safeguarding concern between residents that occurred in August, and was recorded by staff on an incident reporting form. The person in charge informed the inspector that they had spoken with staff and the designated officer about this incident, where it was then agreed that this was not a safeguarding concern. However, this had not been documented nor had the concern been screened in line with the safeguarding procedure and preliminary screening form, which would establish if there were grounds for concern or not. This created a risk that any future suspected concerns raised would not be identified and responded to, in order to ensure residents' protection at all times. This was also of concern due to two previous safeguarding concerns being screened by the person in charge and designated officer who concluded that there were no grounds for concerns for those incidents, yet the safeguarding and protection team did not agree with this and safeguarding plans subsequently had to be developed.
- One safeguarding plan had not been made available for staff in the centre,

however this was printed off on the day of inspection.
- Review dates and the named safeguarding plan co-ordinator required review to ensure that the dates were accurate and actions reviewed within the timeframes identified, and that the co-ordinator reflected the person who was actually responsible for co-ordinating the safeguarding plan actions.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' rights were promoted in the centre. While meals were still delivered from a centralised kitchen, choices in meals were offered and alternatives were available in the centre. Residents' meetings took place and information about advocacy and complaints were available.

A number of developments were noted since the previous inspections also:

- The provider had a Human Rights' Committee in place which had met a number of times this year, minutes of which were reviewed. The inspector got the opportunity to speak with a member of the committee who spoke about the work of the committee to date, and plans in progress for this to evolve and further support residents' rights into the future.
- A recent discussion had occurred at a persons in charge meeting about the Consent Policy and the application of this. The inspector was informed about a review of the restrictive practices policy and procedures to include further guidance on consent, which would further support residents' rights.
- The person in charge was in the process of doing a training course as part of the provider's 'enhancing quality for transition' programme which involved working 1:1 with one resident to support them with their will and preference about their life and future goals. This was an action for quality improvement as part of the management improvement plan submitted to HIQA. This training aimed to supported person-centred care for residents and to promote a culture change towards a more self-directed living model.

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dunwiley OSV-0005489

Inspection ID: MON-0036787

Date of inspection: 08/09/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The Person in Charge has included all agency staff on their training matrix Completion date: 10/10/2022

• The Person in Charge has provided all agency staff with a HSE training needs analysis to complete mandatory training and this training will be completed by 31/12/22. Date for completion: 31/12/22</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The Person in charge in liaison with the Director of Nursing will ensure that all training records are onsite for all staff working in the centre. Date for Completion 31/12/22
• The Person in charge has implemented 'The National Safeguarding Policy' in relation to all incidents and will continue to ensure the policy is followed for all incidents. Completion date: 10/09/22

• The Person in charge will complete designated officer training for safeguarding. Date for completion: 30/11/22

• The Person in charge has submitted a retrospective NF06 notification for alleged safeguarding incident to the regulator. Completion date: 12/09/22.

• The Director of Nursing has reiterated via staff meetings to all Persons in Charge the absolute requirement for timely submission of notifications to the Authority. Completion date 07/10/2022.</td></tr>
</table>

• The Person in charge will ensure all quarterly notifications are notified to the regulator as per the regulations, this will include the omission from the Quarter 2 in relation to bruising. Date for completion: 30/10/22.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• The Director of Nursing has reiterated via staff meetings to all Persons in Charge the absolute requirement for timely submission of notifications to the Authority. Completion date 07/10/2022.

• The Person in charge will ensure that all 3 day and quarterly notifications are submitted to the regulator as per the regulations. Date for completion: 30/10/2022.

Regulation 26: Risk management procedures	Substantially Compliant

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

• The Person in charge has reviewed all risk assessments within the centre to ensure that they accurately reflect the current likelihood of risks and risk score. Completion date: 15/09/2022.

• The Person in charge has reviewed all risk assessments within the centre to ensure that all the information is accurate and reflective of the resident's current situation in relation to location. Completion date: 10/10/2022.

• The Person in charge has reviewed all risk assessments within the centre to ensure that all risks are included on the risk register. Completion date: 10/10/22

• The Person in charge in liaison with the Director of Nursing will ensure that there is triangulation and evidence of the responses provided in relation to escalated risks for the centre. Date for completion: 31/10/22

Regulation 7: Positive behavioural support	Substantially Compliant

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

• The Person in charge in liaison with the Mental health ID team will ensure that all Behaviour Support Plans and management of Mental Health plans are completed were appropriate for residents in Dunwiley and reviewed within the specified time frames. Date for completion: 30/11/2022.

• The Person in charge has ensured that the appropriate restrictive practice forms and debriefing forms are in place and utilised by the staff team in Dunwiley. Completion

date: 15/09/2022. • The Person in charge will ensure that all restrictive practices are documented and reviewed in line with the HSE policy. Completion date: 15/09/22	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • The Person in charge has implemented 'The National Safeguarding Policy' in relation to all incidents and will continue to ensure the policy is followed for all incidents. Completion date: 10/09/22 • The Person in charge will complete designated officer training for safeguarding. Date for completion: 30/11/22 • The Person in charge has submitted a retrospective NF06 notification for alleged safeguarding incident to the regulator. Completion date: 12/09/22. • The person in charge has reviewed all safeguarding documentation to ensure that it is accurate in relation to the person responsible and timeframes for safeguarding plans. Completion date: 10/10/22 • The person in charge will ensure that any safeguarding plans are printed off and accessible to all staff in a timely manner. Completion date: 10/10/22	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	21/12/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	31/10/2022

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	30/10/2022
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	30/10/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation	Substantially Compliant	Yellow	30/11/2022

	every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/11/2022