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:	21 February 2022
Centre ID:	OSV-0005489
Fieldwork ID:	MON-0035404

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 two 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 five 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
Monday 21 February 2022	09:30hrs to 18:45hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

There were four residents living in Dunwiley at the time of inspection. The inspector met with three residents throughout the day. One resident was reported to be at home with family at this time and was not returning until later in the week.

Residents were observed to be supported with staff in line with their needs, and residents who the inspector met with appeared relaxed and comfortable in their environment and in the company of staff members who were supporting them.

There were incompatibilities between residents living in Dunwiley, which was previously identified in inspections in March and September 2021 by the Health Information and Quality Authority (HIQA). The management team were actively working on addressing some of these incompatibilities. Since the last inspection in September 2021, one resident had moved out of the centre to live in their own home in the community, and one other resident was transitioning to a new home, which was planned for the coming days.

The inspector spoke with the resident who was transitioning from the service the week of inspection, and they spoke positively about their new home. They spoke about where their new home was and about some of the new staff that they met as part of the transition. They described how they would have their own apartment. When asked, they said that they were looking forward to the move and spoke about receiving a card from a family member wishing them good luck. They were later observed to be supported with getting their hair done by a staff member who came in to Dunwiley that day especially to support the resident with this. The resident also spoke about wanting to go shopping the following day to get some new clothes, and they said that they were getting a new technological device that day to replace their old one. Overall, the resident appeared happy with the supports given and the arrangements discussed with them for the move. They were observed to be chatting jovially with the person in charge and staff, and it was evident that staff were respectful and treating the resident with dignity and respect.

The inspector also met with two other residents who lived in Dunwiley. One resident was observed in the main sitting-room watching a television programme of choice. They had been out on the bus for a drive earlier in the day and appeared relaxed watching television. They interacted with the inspector on their own terms and with the support of staff in communicating about what they liked.

Another resident was observed to be in the second sitting-room having returned from a bus journey with staff. With the support of staff, they spoke briefly with the inspector about things they liked such as clothes and listening to the radio. The inspector was informed about the resident's preferred routine and about how a structured day was important to them. They were reported to be waiting to listen to their preferred radio programme, and they appeared to be relaxed and comfortable. They were reported to have been involved in baking scones earlier in the day, and

the inspector observed the scones in the kitchen.

Staff spoken with described how residents were getting on at this time, and spoke about the measures in place to help to minimise safeguarding concerns between residents. Staff reported that having familiar staff and ensuring close supervision by staff was very important in supporting residents with behaviours of concern. In addition, the availability of two buses for the centre was also noted to be positive in supporting residents to engage in individual activities of choice. There were four staff supporting three residents on the day, and this was the complement of staff required to support the three residents. Staff spoken with said that that there were sufficient staff on duty to support residents and one staff spoke about how the staff team work well together.

As part of a review of documentation, the inspector reviewed questionnaires that residents had recently been supported to complete to give their views on the service provided. In general, the responses were positive about the service, food, choices and staffing. One resident noted that they were happy that staff were supporting them to move to a different home, and it was recorded that they felt that that they were listened to.

While incompatibilities between residents were evident through a review of care plans and the incidents that occurred in the centre, the staffing arrangements in place, ensuring close supervision of residents who displayed behaviours of concern and environmental control measures helped to minimise the number of incidents between residents. This had helped to reduce the impact of safeguarding risks to residents while they continued to live together.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This centre was one of seven designated centres based on a campus in Co. Donegal. This inspection was carried out to follow up on actions arising from the last inspection by HIQA in September 2021. Since the last inspection, the centre had submitted an application to vary conditions to remove one location from the designated centre, which meant that the centre was now a standalone centre since December 2021.

Since April 2021, as part of the monitoring of this centre and other centres on the campus, the provider was required to submit monthly updates on a quality improvement plan to HIQA. Some actions regarding the governance and management and oversight arrangements that were included on this quality improvement plan were also reviewed as part of this inspection,

Overall, the inspector found that there were improvements in the governance and management of this centre, which led to improved outcomes for residents. However, during the inspection some further improvements were found to be required. This included; the management of complaints, staff training records and protection. In addition, auditing systems, both locally and at a provider level, required strengthening. Improvements in these areas would further enhance the quality and safety of care provided to residents. These will be discussed in more detail throughout the report.

As part of the inspection, the inspector reviewed incidents that had occurred in the centre since September 2021. While the person in charge spoke about a reduction in incidents, there still remained a high number of incidents occurring relating to behaviours of concern. Most incidents involved staff being targeted, and a number of incidents noted the use of a physical intervention that some residents were prescribed as part of their crisis management plan. A review of incidents and discussions with the person in charge demonstrated their commitment to establishing, and subsequently trying to minimise the causes of behaviours. One incident, however, detailed a resident verbally expressing dissatisfaction with a meal choice and the quality of it, and while staff supporting them tried to address this issue, this resulted in staff getting threatened and a PRN medicine (a medicine only taken as required) being used to support the resident in line with their plan. However, the resident's behaviour and their verbal dissatisfaction with the meal had not been identified as a complaint and therefore this was not addressed through the organisation's complaints procedures. The person in charge acknowledged this and undertook to follow up on this post inspection. A review of the complaints documentation showed that generally complaints were identified and responded to in line with the procedures. However, the identification of complaints required improvements to ensure that residents' dissatisfaction with aspects of service was responded to in line with the complaints process, and which would further support learning from behavioural incidents.

There was a staff rota in place which was reviewed and found to be reflective of the staff who were working on the day. A sample of roster records were reviewed for the past two months, and it was found that there was an appropriate complement of staff in place to support the needs of residents and in line with the Statement of Purpose. The use of agency staff was kept to a minimum, and the person in charge explained that regular agency staff were used to help ensure continuity of care. Staff spoken with said that they felt supported, and that they felt that there was enough staff on duty to meet residents' needs.

Staff training records were reviewed and it was found that there were gaps in the records maintained, which meant that the inspector could not verify that all staff had completed the required training. For example, the inspector requested a sample of records for behaviour management training that was required for staff in the use of a physical intervention and which was utilised regularly and part of the behaviour support plans for three out of the four residents; however some records were not available. In addition, the training matrix record maintained did not include all of the staff who were working in the centre and who were noted on the roster. While the person in charge verbally assured the inspector that all staff working in the centre

had completed this mandatory training, improvements were required in the maintenance of records to provide assurances that staff had the appropriate training. Samples of other training reviewed demonstrated that staff had received training in hand hygiene and safeguarding. In addition, there was an outstanding training need for CPR for a number of staff, which was deemed as required training for all staff. The person in charge spoke about the delays in accessing this training as a result of COVID19, and said that there was a plan being progressed to offer staff this training. This need for, and action had been included on the centre's quality improvement plan.

Since the last inspection, the governance and management arrangements had been strengthened. The person in charge had responsibility for two designated centres and was supported in their role with a clinical nurse manager 1 (CNM1) who also worked across some designated centres. There were fortnightly management meetings held with the director of nursing (DON) and the managers under their remit, where topics, including training and policies were discussed. Since September, a number of Quality and Patient Safety meetings had also been held, which had a multidisciplinary input and which included reviews of incidents that occurred in Dunwiley. Minutes of these meetings were reviewed and demonstrated an improvement in oversight arrangements.

However, further improvements were required in some aspects of the local auditing and to strengthen the oversight of induction processes for staff. For example, a sample of behaviour support plans and the safeguarding documentation reviewed showed that the most recent staff member who had commenced in December 2021, had not signed these plans as read. In addition, the most recent local audit to record the number of times a physical intervention was used for each resident contained an inaccurate number for one resident. Furthermore, the provider unannounced six monthly audit had not been completed within the time frames as required under the regulations. The provider audit made available to the inspector was noted to be completed on 18 June 2021, and while the most recent provider audit was reported to have commenced, the completion of this remained outstanding at the time of inspection. This raised a concern about the effectiveness of the provider's oversight and monitoring; particularly at a time when the centre was undergoing changes, including the transitioning of some residents from the centre.

In summary, while there had been improvements in staffing and in governance and management, further improvements were required in the auditing systems, maintenance of training records, identification of complaints and staff induction processes to ensure that the centre achieves regulatory compliance and ensures a safe and quality service at all times.

Regulation 15: Staffing

The centre was resourced to meet the numbers and needs of residents. A roster

was in place which reflected what staff were working on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There were gaps in the training matrix and records maintained, which meant that the inspector could not verify that all staff had the required training required to support residents with their behavioural needs. In addition, not all staff working in the centre were included on the training matrix.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required in the local and provider auditing systems to ensure more effective and robust oversight and monitoring of the centre. Improvements were also required to ensure that all complaints were identified and that the induction processes for new staff were robust. Unannounced six monthly provider audits were not completed within the time frames as required in the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

While complaints were generally responded to and followed up in line with the procedures, one incident where a resident expressed upset and verbal dissatisfaction about a meal was not identified as a complaint, and therefore not followed up in line with the provider's policy and procedures.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents were supported with their assessed needs and had familiar staff in place to ensure that their needs were met. However, there were incompatibilities between residents living in Dunwiley, which was reflected

through incident reports and identified safeguarding risks.

At the last inspection one resident spoke with inspectors about how they did not want to live in Dunwiley, and they became upset when talking about this. Since then, the inspector found that this resident was supported through the safeguarding process, with a safeguarding plan in place, and a multidisciplinary review had been carried out to discuss this issue. The resident had also been supported to access psychological support and was reported to be doing well. While the inspector did not get the opportunity to speak with this resident, there was evidence in the questionnaire completed by the resident and in documentation, which noted the family's satisfaction with the service in Dunwiley.

Since the last inspection one resident had moved to a new individualised service in the community and another resident was transitioning to a new home during the week of inspection. Through discussions with the resident, members of the management team, and a review of documentation, the inspector found that the resident who was moving to a new home this week, was supported with this transition and that regular multidisciplinary meetings were held to review the resident's assessed needs and ensure that future living arrangements would meet their needs. The resident spoke positively about this move and appeared to be excited about getting their own home.

Regular resident meetings occurred where opportunities to discuss a range of topics occurred, such as advocacy, community activities, shopping choices and aspects of staying safe. While main meals were still provided from the centralised kitchen on the campus, residents had options to buy items in the local supermarket and to cook some meals in the kitchen. One resident spoke about having pizza. The kitchen cupboards contained a range of food items, snacks and beverages, and on the day of inspection some residents had been involved in baking scones. A review of documentation and discussions with staff demonstrated that residents' choices with regard to activities were respected, with some residents noted to enjoy attending religious ceremonies, going on overnight stays, attending swimming sessions and going for walks and having coffee out in the local community. The management team spoke about plans in progress to review the premises with a view to enhancing the kitchen space, which would provide more opportunities for independence in meal planning and cooking.

A review of documentation found that residents' health, personal and social care needs were assessed and kept under review. Annual review meetings were held with the maximum participation of residents and their family members, and a sample of meeting notes indicated that a comprehensive review of the residents' current needs were undertaken. Residents who required supports with behaviours of concern had plans in place, which had a multidisciplinary input. These plans were kept under regular review and outlined triggers to behaviour relating to for example, environmental causes. It was noted in two support plans reviewed that residents' could be impacted by a noisy environment and other people's behaviours. Three residents' crisis management plans included a physical intervention and the use of PRN medicines if risks to self or others could not be managed proactively. The sample of plans reviewed were found to be up-to-date and comprehensive in

nature.

As noted previously, there were a number of incidents occurring which related to residents displaying behaviours of concern. For the most part, these incidents related to staff being targeted; however the impact on other residents' quiet enjoyment of their home were affected as a result. Any concerns of a safeguarding nature affecting residents had been identified and safeguarding procedures had been followed. In addition, each resident had an overarching safeguarding plan which had recently been reviewed and were found to be specific to the safeguarding risks identified for that resident. It appeared, and staff verified, that in general residents' behaviours of concern could have a knock-on effect on other residents' presentation and may result in further behavioural incidents. This demonstrated that incompatibilities between some residents remained.

A review of the risk management systems found that there was an improvement in the management of risk, with risks being identified, assessed, risk rated and control measures put in place to mitigate against the risks. The centre's risk register was found to be up-to-date and the risk assessments in place were found to be under regular review. Risks for residents relating to use of technological devices, as required in the provider's policy, were in place for two residents. The person in charge completed assessments for two more residents before the end of inspection, in line with the organisation's policy.

Overall, residents were found to be supported in line with their needs. Staff and the local management team were proactive in ensuring that residents' needs were met and that safeguarding risks were minimised. However, incompatibilities between some residents remained which impacted on some residents' safe and quiet enjoyment of their home at all times.

Regulation 25: Temporary absence, transition and discharge of residents

The person in charge ensured that a comprehensive transition process was in place for a resident who was moving from the service. This process included comprehensive assessment of the resident's needs, regular multidisciplinary meetings, family involvement and discussions and plans developed with the resident for a safe and smooth transition.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk management policy and procedure in place which was up-to-date. The risk management system in place in the centre ensured that risks were appropriately identified, assessed and included control measures which were kept

under regular review.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had comprehensive assessments completed on their health, personal and social care needs and care and support plans were developed where required. Annual reviews were completed with the participation of residents and their representatives.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required supports with behaviour of concerns had support plans in place, which had a multidisciplinary input. Crisis management plans were developed to support residents with behaviours that may cause a risk to self and others. Where restrictive practices were in place there was evidence that residents and their family members were consulted.

Judgment: Compliant

Regulation 8: Protection

Where safeguarding concerns arose, these were taken seriously and responded to in line with the organisation's procedures. Residents who were affected by safeguarding risks had access to multidisciplinary supports. However, incompatibilities between residents remained an issue. While control measures in place, such as staffing, separate activities and close supervision were for the most part effective in minimising risks, it was noted that some residents' behaviours of concern remained a safeguarding risk to others.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There was evidence that residents' religious preferences and individual rights were

respected in the centre. While main meals were still provided from a centralised kitchen on the campus, residents were given choices about meal options and facilitated to purchase items from the supermarket to cook in the house. Plans were in progress to develop the internal environment, which would create more opportunities for cooking meals in the home. Residents were supported with referrals to advocacy services, as required.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dunwiley OSV-0005489

Inspection ID: MON-0035404

Date of inspection: 21/02/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The Person in charge/ Director of Nursing has completed a further review of the training matrix to ensure that all staff are included on same – Completion date: 14/03/22 2. All staff within the centre have completed the training on supporting adults sexuality in residential settings – Completion date: 28/03/22 3. The Person in Charge has scheduled all staff for outstanding CPR training and these will be completed by the end of May 2022 – Date for Completion : 31/05/22 4. The Person in Charge has scheduled 2 staff for outstanding Studio III training and these will be completed by the end of May 2022 – Date for Completion : 31/05/22 5. The Person in Charge has advised staff of all outstanding training on HSELAND that they require to update and complete by end of May 2022 – Date for completion 31/05/22	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Regional Director of Nursing in conjunction with the CNM3 for quality, risk and service user safety and persons in charge are currently undertaking a review of all audits in place will be conducting a review of the audits in place - Date for completion: 30/04/22 2. Following completion of this review any improvements and actions identified will be implemented to ensure auditing systems that are in place are effective and robust – Date for completion 31/05/22 3. The Person in charge has discussed complaints management with all staff and this will be on the agenda for staff governance meetings within the centre – Completion date: 25/03/22 4. The most up to date provider 6 monthly and annual review are now onsite and available within the centre – Completion date:14/03/22	

5. The Provider representative has developed a schedule to ensure that all 6 monthly and annual reviews are completed within the required time frames and reports are provided to the centre in a timely manner – Completion date: 31/01/22	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: 1. The Person in charge has discussed complaints management with all staff and this will be on the agenda for staff governance meetings within the centre – Date for completion 25/03/22	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: 1. The Person in charge will ensure that all safeguarding incidents continue to be responded to and managed in line with safeguarding of vulnerable adults at risk of abuse policy – Completion date 21/02/22 2. The Person in charge in liaison with the Director of Nursing and the Multi disciplinary team will continue to monitor the compatibility of all residents in this centre – Date for completion 14/03/22 3. One resident moved from the centre in November 2021 and another resident moved to their new home in February 2022 this now means that only 3 residents currently reside in this centre and there are currently no plans to fill the vacancies – Completion date: 24/02/22	

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	31/05/2022
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	31/05/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an	Not Compliant	Orange	31/05/2022

	unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	25/03/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	14/03/2022