Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Riverside
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	25 and 26 July 2023
Centre ID:	OSV-0008152
Fieldwork ID:	MON-0035518

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 25 July 2023	14:55hrs to 18:50hrs	Angela McCormack	Lead
Wednesday 26 July 2023	09:40hrs to 14:20hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor compliance with the Care and Support Regulations (2013). The inspection was carried out over two half days. Overall, this inspection found that the health and wellbeing of residents who lived at Riverside were promoted and that individualised care and support was provided.

On arrival to the centre, the inspector met with staff members and the clinical nurse manager 1 (CNM1). The person in charge arrived to the centre shortly after and was available throughout the inspection. One resident was observed to be relaxing in the sitting-room and they acknowledged the inspector in their own way. The inspector gave staff a document called 'Nice to Meet You', which inspectors use to help explain to residents the purpose of their visit. Throughout the course of the inspection, the inspector got the opportunity to meet with all four residents and spoke with five staff members who were working over the inspection days.

All residents required supports with communication. Some residents did not communicate verbally, therefore the inspector did not get to hear the views of residents about the service provided. However, the lived experiences of residents was established through observation, a review of various documentation and speaking with staff and the management team.

The Chief Inspector of Social Services had been notified of a number of safeguarding concerns in 2023. Eight of these related to the negative impact of one resident's behaviours on their peers. One resident had experienced a deterioration in their mental health presentation in recent months, which had impacted on their peers at times. This was a known safeguarding risk and the management team were responsive to this and measures had been put in place to reduce the risk of this occurring. This included increased staffing day and night to provide one resident with 2:1 staffing. Other measures included planning separate activities, the use of the environment and staggered mealtimes. Staff spoken with said that these strategies generally were effective. The local management team were aware of the compatibility issues in the centre and spoke about meetings that were occurring that were reviewing various residents' needs and future living options.

On the first day of inspection, the inspector met with all residents. One resident attended a day service, and they met with the inspector on their return. They interacted in their own way. They appeared happy and were observed happily interacting with a staff member. Another resident had been swimming in a local hotel, and met with the inspector on their return. They did not communicate verbally, however they spent time with the inspector throughout the evening entering the room the inspector was in and interacting in their own way. Another resident was met with in the second sitting-room where they were observed relaxing with staff. With support from staff, they used gestures and words to speak about a peer who had died since the last inspection. Staff were observed to be responsive

and caring in their responses.

Staff spoken with described ways in which residents communicated and about how they were offered choices. One resident had commenced using a picture communication system and staff showed the inspector how the resident had chosen a particular activity. There was a visual schedule in place in the hallway which included all residents' weekly activity schedule. Staff spoken with said that this supported residents to know what was happening each week. Staff were due to undertake training from the Speech and Language Therapist (SLT) in various communication methods to further support residents with communication preferences. This will be discussed further in the report.

Riverside house was found to be well maintained, nicely decorated, clean and homely. Since the last inspection by the Health Information and Quality Authority (HIQA) in October 2022, new flooring had been installed in the hallway and communal rooms, damaged doors had been repaired, some internal painting had been completed and the kitchen units had been upgraded. There were plans in progress to get the external walls and some internal walls re-painted. The provider had applied to vary conditions of the house in January 2023, to reduce bed numbers and to change the function of two unused bedrooms to a multipurpose room and a staff room. These rooms were in progress of being developed for this use.

In addition, the provider had a plan since 2021 to reconfigure the kitchen area for the purposes of promoting the full capabilities and independence of residents. This action remained in the early stages of development, and was not completed. In the interim, arrangements had been put in place to support residents to cook and bake if they so wished. Staff spoken with said that all residents currently living in Riverside could access the kitchen area and had access to all the equipment to cook and bake if they so wished and that was facilitated. There was a counter area in the dining-room, with easy access from an open hatch from the kitchen to the dining-room, which allowed for greater counter space for baking activities for example. The plans for the reconfiguration of the kitchen area required further review to ensure that it remained relevant to the needs of the current residents.

Each of the residents had their own bedroom which had been personalised to their individual preferences with personal photos and ornaments displayed throughout their rooms. Some residents also had their own television in their bedroom. One resident was reported to prefer minimal furnishings and this was was observed also. The management team reported that they were in the process of seeking alternative options to curtains in this bedroom in line with preferences displayed by the resident.

Residents had access to a spacious garden to the front and rear of the property, which was accessible through double doors leading from the sitting-room and dining-room. There was a ramp and hand rails leading to the front door to support residents with mobility needs. The front garden was beautifully decorated with potted shrubs, flowers, painted stones, garden ornaments and bird feeders on the trees. There was garden furniture for residents to sit out if they chose too. In addition, some residents were reported to enjoy gardening and there was a raised

planter in the back garden.

A range of easy-to-read documents, posters and information were displayed in the centre in prominent locations throughout the hallways. This included; fire evacuation procedures, easy-to read information on the procedure for making complaints, national advocacy information, a pictorial staff roster and infection prevention and control protocols. It was noted that there was a certificate on display awarded for a baking competition on the campus that occurred during 2022 and the inspector was informed that one resident in particular enjoyed baking.

Residents were supported to engage in activities from their home in line with their individual needs, abilities and wishes. Activities that residents reported to enjoy and that were observed in various documentation included; going to religious amenities of choice, fishing, knitting, reflexology, gardening, swimming, aqua aerobics, going for day trips and out for meals. One resident was recently supported to go to another county for a hotel break and it was reported that there were plans for one resident to try out surfing. One resident attended a day service Monday to Thursday. Another resident was waiting to commence an external day service. This had been noted as a need at their annual review in 2022, and this remained outstanding.

A number of staff spoken to throughout the inspection had worked in the service for a number of years. It was evident that they were very familiar with the individual support needs of each resident and about what residents' enjoyed. In addition, staff appeared very knowledgeable about residents' behaviour support plans and measures contained in safeguarding plans. Staff were observed supporting residents in line with the care plans and in a respectful and dignified manner.

'Human rights' training had been identified by the provider as a site specific training requirement. The rights of residents were promoted through weekly residents' meetings, where consultation occurred. Meeting notes recorded expressions, reactions and gestures that residents displayed in response to topics discussed, which demonstrated that the service strived to establish residents' views and choices. However, improvements in communication supports provided to residents would further aid residents to express their will and preferences more effectively.

Overall, inspectors found that Riverside provided person-centred care and support and strived to ensure that all residents' wellbeing was protected and that they were safe.

The next sections of the report describe the governance and management arrangements and about how this impacts on the quality and safety of care and support provided in the designated centre.

Capacity and capability

Overall, this inspection found that the management systems in place in Riverside ensured that the service was well governed and monitored. While there were some areas identified for improvements on this inspection, most of these actions had been identified by the management team through their own monitoring systems and actions were either in review or in progress for completion.

The local management team comprised a person in charge who reported to the director of nursing (DON), both of whom were based at the campus. The person in charge was supported in their role by a clinical nurse manager 1 (CNM1), who completed some management tasks. Both the person in charge and CNM1 had responsibility for one other designated centre which was also based on the campus. The local management team were available throughout the inspection and demonstrated very good knowledge of the centre and the individual needs of residents, some of which had changed in recent months.

The staffing skill mix consisted of nurses and healthcare assistants. There were five staff working during day hours and three waking night staff each night. Increased staffing numbers had been implemented in recent months in response to the changing need of one resident, which meant that this resident now had 2:1 staffing. Staff spoken with reported that this was going well and that it generally was effective in supporting the resident and in safeguarding other residents. There were no staff vacancies at the time of inspection and any staffing gaps as a result of leave were filled by regular agency and regular relief staff across the campus. This helped to ensure that continuity of care was provided to residents and that familiar staff were available to support residents who required increased staff supports for their overall wellbeing. Staff spoken with said that they were well supported and could raise any concerns at any time to the members of the management team.

The service had in place a training plan which included a list of mandatory and site specific training for staff working in the centre. A review of the training plan and sample of staff records demonstrated that in general staff had completed all of the required training. A risk assessment had been completed to assess risks while staff were waiting for identified training. This included the control measure that only trained staff supported the resident who required the medication. One staff who was outstanding in this training was completing it on the day of inspection and this was noted to be reflected on the roster.

Staff were supported through annual 1:1 meetings with their line manager, and through attendance at various meetings. Staff were facilitated to raise concerns or topics for discussion through attendance at bi-monthly team meetings. Staff spoken with said that they were invited to attend team meetings and multidisciplinary team (MDT) meetings for residents, and where staff could not attend there was a sign-off sheet in place for staff to read and review the discussion points. These meetings were found to be comprehensive and covered a range of topics including residents' individual support needs and safeguarding.

The inspector found that there were good systems in place for monitoring and ensuring oversight of the centre. This included an annual schedule of audits to be completed at set intervals throughout the year. Areas that were under regular

auditing included; restrictive practices, safeguarding, complaints, health and safety, fire safety, finances and incidents. The local management team were actively reviewing trends in incidents. In addition, there was evidence that behaviours that occurred were under ongoing review to support residents involved in these incidents and to minimise any risks. The review of behavioural incidents generally reviewed if other residents were impacted negatively as a result. However, for some incidents where property had been damaged, it was not clear if the possible impact on other residents had been considered. The person in charge followed up on this on the day of inspection to establish if one of the incidents reviewed and discussed could have impacted another resident. The local management undertook to ensure that this was considered in any future incidents that involved property damage.

The provider ensured that six monthly unannounced audits and an annual review of the service occurred as required in the regulations. These included consultation with residents and their representatives as appropriate. In addition, the service had a quality improvement plan (QIP) which included actions identified through the provider audits, risk assessments and HIQA inspections. This was found to be kept under regular review to review the progress of actions. However, it was found that one action that was noted as being complete had not been fully completed, and the QIP did not include further actions that were in progress to achieve the desired action outcome. The person in charge updated this on the day of inspection when it was brought to their attention.

Overall, the management team demonstrated that they had the capacity and capability to manage the service and to ensure that a safe and high quality service was provided to residents.

Regulation 15: Staffing

There appeared to be enough staff to meet the needs and numbers of residents living in Riverside. Staff levels had been increased in recent months, by one staff day and night, to provide supports to a resident whose needs had changed and now required 2:1 staffing supports.

There was a planned and actual staff roster in place which accurately reflected who was working each day of inspection. The rosters were well maintained and kept under ongoing review by the local management team. There were no staff vacancies at the time of inspection. Leave arrangements were managed through cover by a cohort of regular agency staff which helped to ensure good continuity of care.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had in place a list of mandatory training that all staff required to ensure that they had the competence and skills to support residents. In addition, there was a list of site specific training for staff working in Riverside, which included Human rights training for example.

There was an annual training plan in place to track staff training for both the mandatory and site specific training. Staff had undertaken the required training, with one staff completing the Buccal midazalom training on the day of inspection. A risk assessment had been developed with control measures in place to ensure that the risks of staff not yet having the required training was minimised. For example; staff who were awaiting emergency medication training did not provide 1:1 support to a resident who required this medication.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the governance and management of the centre was found to be robust, with good arrangements in place for the ongoing monitoring and oversight of systems in the centre.

The following areas required improvements;

- The quality improvement plan was not fully clear on the areas requiring improvements and the actions in progress. For example; the QIP noted that an action regarding communication were completed; however this work was ongoing. The local management team updated this on the day.
- Some notifications, while submitted as required, were submitted outside the required time-frames. This required improvements.
- While reviews of behavioural incidents did generally review and note if there was any impact of behaviours on other residents. However for some incidents where property damage occurred, it was not clear that it had been considered that this could possibly impact on the resident whose property was damaged, even if they did not directly witness this.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge ensured that all events that were required to be notified to the Chief Inspector of Social Services were completed.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider ensured that there were procedures and systems in place to address and resolve issues or concerns. The complaints procedure was also available in an easy-to-read version and included an appeals process. Complaints audits were completed regularly to ensure effective monitoring and oversight of complaints. Residents' questionnaires were completed throughout the year to try to establish residents' satisfaction with aspects of the service.

Judgment: Compliant

Quality and safety

Overall, it was found that residents living in Riverside were provided with person-centred care and support. There were good systems in place to ensure that residents' needs were regularly monitored and changes in need were found to be responded to. However, there remained incompatibility between residents which created a protection risk at times. In addition, some residents required further supports with communication and there was no time-frame for one resident to commence an external day service placement. The local management team were aware of these issues and these were under ongoing review.

All residents living in Riverside required supports with communication. While it was found that residents had an initial assessment of their communication needs completed in July 2022, most were waiting full assessments, as recommended through this initial assessment. Residents referred to SLT were placed on a prioritization list and one resident had an augmented form of communication implemented. While it was evident through MDT meetings and various documentation that every effort was being made to support residents with their communication preferences, there remained some gaps in communication supports. The inspector was informed about a plan that was in progress for all staff to undertake training in communication methods, which aimed to address these gaps and enhance the supports provided to residents to meet their communication needs. At the time of inspection, this action was not fully completed.

The inspector found that rights were promoted in the centre. Residents were supported to practice their faith and to visit religious amenities when they chose to. In addition, residents were consulted with through regular residents' meetings, where 'human rights' was a regular agenda topic. Easy-to-read versions of various topics were used to aid understanding. However, as noted above, improvements in communication supports would further support residents to communicate their will

and preferences more effectively.

Residents' needs were found to be kept under ongoing review. Each resident had a comprehensive assessment completed of their health, personal and social care needs. A range of care and support plans were developed to guide staff in the supports required. Staff spoken with were knowledgeable about the support needs of residents. Some residents' health and wellbeing needs had changed in recent months. It was found that these changing needs were responded to and that residents were facilitated to attend a range of allied healthcare professionals. One resident who experienced a decline in their mental health in recent months was kept under ongoing review with MDT meetings occurring. Where risks to mental health occurred, these were identified and assessed as required.

Residents who required supports with behaviours of concern had comprehensive behaviour support plans in place which included multidisciplinary therapy team (MDT) input. As noted above, one resident experienced a decline in mental health which resulted in an increase in behaviours of concern. Trends in behaviours were under ongoing review by the management team and MDT to try to establish and alleviate the cause of the behaviours. Where additional supports were required these were implemented, such as increase in staffing supports. Any restrictive practice used was found to be kept under regular review and assessed so as to ensure that they were the least restrictive option and proportionate to any risks identified. This included ongoing monitoring of the use of PRN (medicines only taken as required) medicines, for which there were clear protocols in place.

Overall, there were effective systems in place for the management of risks. Risks identified were found to be ongoing review by the local management team and included any additional control measures required to reduce the risk. There were also good arrangements in place to ensure fire safety in the centre; including a system for ongoing auditing and checking of fire safety. Fire drills occurred regularly to ensure that all resident could be evacuated safely. Safety issues, including fire safety, were found to be discussed at staff meetings.

As noted previously, there were incompatibilities between residents living in Riverside. This was under ongoing review through regular 'compatibility meetings', one of which had occurred on the day of inspection. The management team spoke about the discussions that took place which aimed to address individual residents' needs and to address the compatibility issues. While there was no specific plan in place, this was being worked on. Until the compatibility issues were addressed, safeguarding risks remained. These risks were managed through environmental strategies and increased staffing, which were reported to be generally effective in protecting residents.

In summary, this inspection found that the service provided to residents strived to ensure that it met residents' needs and provided them with safe and person-centred care and support. Some improvements as noted throughout the report would further enhance the good quality care and support provided.

Regulation 10: Communication

All residents living in Riverside required supports with communication. Each resident had a Communication support plan/dictionary in place to guide staff on residents' communications and included what particular gestures/facial expressions may mean.

- However, while initial assessments had been completed with regard to SLT, further assessments had been recommended and were not yet completed for all residents. There were plans to provide training to staff in communication methods to further support residents to use their preferred communication methods. This was not fully completed at the time of inspection.

Judgment: Substantially compliant

Regulation 13: General welfare and development

In general, residents were supported to participate in activities and leisure interests that were meaningful to them. Where residents preferred a slower pace of life, this was facilitated in line with their particular needs. Residents had good contact with family and were supported to maintain links with their family and community. However, the following was found:

- One resident who was assessed as requiring an external day service had not yet started this placement, despite approval agreed for this service to be provided.

Judgment: Substantially compliant

Regulation 17: Premises

The following was found in relation to the premises. The local management team were aware of this, with plans in place to address them;

- Two doors required upgrading.
- External painting was required.
- Replacement curtains/window covers for one resident's bedroom was required.
- There was some peeling painting in areas in the hallway.
- In addition, the provider's action plans as noted on previous inspection reports to address issues with size and accessibility of the kitchen had not yet commenced or been completed. This required further review.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider ensured that there was a policy and procedure in place for the management of risk. There were good arrangements in place for risk management, including emergency plans in the event of any adverse event. Risks affecting residents and the operation of the centre were found to be kept under ongoing review and where required, escalated through the management structure. For example; the risks associated with a gap in mental health supports were recently escalated through the line management structure.

Judgment: Compliant

Regulation 28: Fire precautions

There were good arrangements in place in the centre for fire precautions including; fire containment measures, fire fighting equipment, staff training and ongoing regular checks on fire safety management systems. In addition, regular fire drills under various scenarios and with a variety of staff were completed to ensure that all residents could be evacuated to safe locations. Residents had individual personal emergency evacuation plans in place to guide staff in the supports required. Fire safety was discussed regularly at staff meetings and residents' meetings.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that comprehensive assessments on residents' health, personal and social care needs were completed. These were kept under ongoing review and updated where changes in need occurred. Residents' annual review meetings occurred with the maximum participation of residents and their representatives. Where residents chose not to attend, this was noted. Residents were supported to identify personal goals for the future, and these were kept under regular review for completion.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health outcomes. Residents' health and wellbeing were found to kept under ongoing review, with multidisciplinary team input provided as required. Residents were facilitated to undertake national screening programmes, vaccination programmes and to attend any recommended healthcare appointments.. Some residents had complex healthcare needs and it was found that needs and supports were kept under regular review to ensure that the best supports available were sought. Where there were gaps in supports provided in the area of mental health recently, the local managers had escalated this risk to the senior managers and put in measures to manage the risks.

Residents had end-of-life care plans in place, as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge ensured that staff had up-to-date knowledge and skills to support residents to manage their behaviour. Residents who required supports with behaviours had up-to-date support plans in place which included MDT input.

It was clear that every effort was made to identify and alleviate the cause of resident's behaviours of concern, and this was found to be under ongoing and regular review with members of the MDT. Staff spoken with were very knowledgeable about how to support residents who displayed behaviours of concern.

Restrictive practices that were in place in the centre had been assessed and clearly outlined the protocols around their use. They were subject to regular auditing and found to be reviewed to ensure that they were the least restrictive option and for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

The person in charge ensure that staff received training in safeguarding. Where safeguarding concerns arose, these were followed up in line with the safeguarding procedures and safeguarding plans were developed, as required. These were kept under ongoing review and noted to be discussed at team meetings. Staff spoken

with were aware of how to promote the protection of residents as outlined in safeguarding plans. However, the following issue was found;

- There were compatibility issues between residents, whereby some residents were vulnerable to the impact of behaviours displayed by peers. While the risks were in general well managed through increased staffing levels, the use of the environment and staggered mealtimes; the risks remained.

Residents' protection were promoted through ongoing review of incidents, which noted if there was any impact on other residents if behaviours occurred. However, at times it was not clear if consideration was given as to the effect on residents if their property was damaged due to the behaviours of a peer. This is covered under regulation 23: governance and management.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Human rights training was included as part of the centre's training plan and there was evidence that a human rights based approach was taken in the delivery of care. It was clear that residents were provided with person-centred care and support and were supported to make choices in their lives. In addition, it was evident that residents' religious preferences were respected. Residents also had access to independent advocacy services, as required.

Regular residents' meetings took place, where choices were offered and discussed. While main meals were delivered from the campus kitchen, residents could choose to cook meals in the centre's kitchen also if they so wished. Improvements in communication supports would further support residents to make choices and express their will and preferences. This is covered under regulation 10 : Communication.

The provider had in place a human rights' committee who met regularly and which demonstrated a commitment to promote a human rights based approach in the delivery of services. A recent discussion at the committee reviewed 'decision-making' and discussed training for supporting this.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Riverside OSV-0008152

Inspection ID: MON-0035518

Date of inspection: 25/07/2023 and 26/07/2023

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge has reviewed the Centre's Quality Improvement Plan and included the outstanding communication training for residents. Date completed: 30/07/2023. • The Person in Charge will ensure that all notifications for the designated centre will be submitted to the Chief Inspector within the required time frames. Date completed: 09/08/2023. • The Person in Charge and Clinical Nurse Manager 1 will ensure that when reviewing incidents in the designated centre that they are cognisant of the possibility of residents being impacted by incidents if their property is damaged by another person. Date completed: 09/08/2023.	
Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: • The Person in Charge has reviewed and updated the training matrix to include the communication training that has been identified as a requirement by the speech and language therapist. Date completed: 31/07/2023 • The Person in Charge has agreed a schedule of training dates and topics with the speech and language therapist. Date completed: 11/07/2023. • The Person in Charge will ensure that all staff complete the scheduled communication training identified by the speech and language therapist. Date for completion:	

31/12/2023.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The Person in Charge will follow up with training services in relation to an external day service placement for one resident. Date for completion: 31/08/2023.
• The Person in Charge will ensure that an external day service placement is secured for one resident. Date for completion: 31/12/2023

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Person in Charge has liaised with the contractor to progress the identified painting works to the external of the designated centre. Date for completion: 30/09/2023.
• The Person in Charge has liaised with the contractor to progress the identified painting works to the internal of the designated centre. Date for completion: 31/12/2023.
• The Person in Charge will monitor the completion of the identified painting of the designated centre through regular review of the centres quality improvement plan.
• The Person in Charge has liaised with the maintenance manager and the scheduled works to replace two fire door in designated centre has been completed.
Date completed: 10/08/2023.
• The Person in Charge will ensure that suitable window coverings for one resident's bedroom is sourced.
Date for completion: 30/11/2023.
• The Person in Charge, Director of Nursing in liaison with the multi-disciplinary team will complete a review of the requirement to make amendments to the centres kitchen facilities. Date for completion: 30/09/2023.

Regulation 8: Protection	Substantially Compliant

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

• The Person in Charge and Clinical Nurse Manager 1 will ensure that when reviewing incidents in the designated centre that they are cognisant of the possibility of residents being impacted by incidents if their property is damaged by another person.
Date completed: 09/08/2023.

• The Person in Charge will continue to attend bi-monthly safeguarding meetings and will continue to respond to any safeguarding concerns as they arise within the centre.

• This centre is included in the overall decongregation plan for Ard Greine Court campus and there is a schedule of monthly compatibility and decongregation meetings to progress this process. Date for completion: 15/08/2023 and ongoing

• The Person in Charge in conjunction with the staff team and multi-disciplinary team have commenced the process to establish the will and preference of the resident regarding future living arrangements. Date for completion 30/10/2023

• The Person in Charge and staff team will support the resident when will and preference is completed to assess compatibility with other individuals. This will be completed in all areas of the resident's life. Date for completion: 31/12/2023.

• The Person in Charge in conjunction with the staff team & multi-disciplinary team will continue to progress the compatibility assessments for all residents. Meetings regarding compatibility are held on a monthly basis and a representative from the centre attends all meetings. Date for completion: 15/08/2023 and ongoing.

• The Person in Charge will continue to monitor, review (and update when necessary) all protection related risks. Date for Completion: 31/08/2023 and ongoing.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/12/2023
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/12/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair	Substantially Compliant	Yellow	31/12/2023

	externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/12/2023
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	09/08/2023
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support	Substantially Compliant	Yellow	09/08/2023

	provided to residents.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2023