Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	James Connolly Memorial Residential Unit
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	07 and 08 December 2022
Centre ID:	OSV-0002502
Fieldwork ID:	MON-0037815

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 December 2022	14:00hrs to 19:30hrs	Úna McDermott	Lead
Thursday 8 December 2022	08:45hrs to 12:45hrs	Úna McDermott	Lead
Wednesday 7 December 2022	14:00hrs to 19:30hrs	Mary McCann	Support
Thursday 8 December 2022	08:45hrs to 12:30hrs	Mary McCann	Support

What residents told us and what inspectors observed

This was an unannounced follow up inspection to an inspection that took place in June 2022. At that time, the inspector found non-compliance in regulations 13 and 15. This related to the provider's inability to ensure that a sustainable number and skill of staff was provided in order to meet the assessed needs of all residents living in the designated centre. In addition, the inspector found that although COVID-19 restrictions were removed, residents had not returned to their day service and due to a shortage of nursing staff some residents were unable to leave the centre. In response to these findings, the provider submitted a compliance plan which detailed the actions that they planned to take in order to bring this centre back into compliance. The purpose of this inspection was to assess the provider's capacity and capability to sustain their ongoing response to the actions required in order to return to full compliance.

At the time of inspection in the James Connolly Memorial Residential Unit, the inspectors found that there were ongoing changes to the governance and management arrangements in place and these were in the early stages of establishment. Some actions had been implemented in order to enhance the day to day lived experience of the residents at this centre, however, in general the level of progress required review. Other actions identified by the provider and submitted as part of a compliance plan following the June inspection, were not achieved within the timelines provided. Furthermore, an urgent compliance request was issued due to concerns identified in relation to risk management procedures (regulation 26). These will be discussed in later in this report.

This centre is a congregated setting and institutional in design. It is a large two-storey building with residents' living quarters on the ground floor and a staff canteen and administrative offices upstairs. The living quarters comprised of two communal sleeping dormitories, one for male and one for female residents, and some single occupancy bedrooms. Facilities for bathing and showering were provided. There was a large dining room and a kitchen where a professional catering service was provided. There was a smaller kitchenette and dining area next door for residents to use when the main kitchen was closed. Towards the front of the building there was a large sitting area, where a television was playing music. There was an activity room and a multi-sensory room close by. The number of residents living at the James Connolly Memorial Residential Unit had reduced to nine since the last inspection and the provider had plans in place to enhance the lived experiences of some residents due to these changes. In addition, the registration of this designated centre had a restrictive condition attached which means that the provider is required to transfer residents to more appropriate living arrangements by 31st December 2023.

On the afternoon of inspection, there were nine residents living at this designated centre. One resident was gone on a Christmas outing with the activities co-ordinator. Eight residents were at the centre. Two residents went out on the bus

later that afternoon. The staff on duty told the inspector that the day service remained closed and that residents participated in centre based and community based activities. However, the staff explained that some residents had a diagnosis of epilepsy and needed the support of a nurse when accessing their local community. This was not always possible as the nurse of duty was required to remain at the designated centre in order to support the residents there. This meant that at times, four residents were unable to leave the centre in accordance with their wishes due to the lack of qualified and skilled staff to accompany them. This will be expanded upon later in this report.

The nine residents in this designated centre had a range of physical, sensory and medical conditions and had high support needs. Throughout the afternoon, evening and morning of inspection, the inspectors spent time with them all. They were observed lying on the couches in the sitting room or sitting in their chairs, while listening to music on the television. One resident was moving from the sitting room to the activity area. Two other residents were sitting in a smaller relaxation room. Two more were in an activity room with the activities co-ordinator. In addition, the inspectors spent time in the dining room where the residents had their evening meal. The inspectors also spent time speaking with four staff members who were employed in the role of 'healthcare assistant'. These discussions provided inspectors with information on the lived experiences of the residents as the residents' views on the service could not be established due to their communication needs. Therefore, discussions with staff, observation of the day to day routine and review of the documentation informed the findings of this inspection.

The next two sections present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to the residents.

Capacity and capability

As outlined above, this inspection was carried out to monitor compliance with the regulations and to review the provider's actions from the inspection completed in June 2022.

The management structure in this designated centre had changed since the previous inspection. The person in charge was on leave and an acting person in charge was present. They reported to an assistant director of nursing (ADON) who had commenced this role recently. There was a clinical nurse manger post (CNM1) provided to support the work of the person in charge. However, this post was vacant since July 2022. As previously outlined, there was one staff nurse on duty on the days of inspection. Due to their requirement to provide nursing cover, the inspectors did not speak with them at length.

On arrival at the centre, the inspectors found that a vaccination clinic was taking place. The staff nurse was assisting with this. They told the inspectors that the

person in charge was on leave. They were unsure of the identity of the person providing cover but were aware that they could contact the ADON. Shortly afterwards, a person in charge from a designated centre close by arrived and they told the inspectors that they were providing cover that day. However, they had limited information available to them regarding this designated centre. The ADON arrived later during the afternoon.

The statement of purpose was available at the entrance to the centre however, the inspectors found that it required review and updating. This was requested and the amendments required were completed in a timely fashion which ensured that the copy provided on the day contained the information required under Schedule 1 of the regulations.

A review of policies and procedures as required under Schedule 5 of the regulations was completed. This was a follow up to the actions agreed with the provider following on from the June 2022 inspection. The inspectors found that although the policy on positive behaviour was updated, the policy on the use of restrictive practices had expired and required review. The provider had an audit tool in place which allowed for monthly checks on the policies in place and the staff signing of same. However, this was last updated in September 2022 and therefore was not effective.

The staff roster was reviewed and in the main, it was found to provide an accurate reflection of the staff that were on duty on the day of inspection. However, as previously referred to above, the CNM1 post was vacant and on the day of inspection a person in charge from another designated centre appeared to be providing cover. However, they were not named on the roster. In addition, there were numerous changes to the roster provided. For example, during one week in November 2022 there were in excess of 50 changes to the roster and this trend of ongoing changes continued throughout the sample viewed. This meant that consistency of care and support was not provided.

On the days of inspection, there was one staff nurse on duty, four healthcare assistants and one activities co-ordinator. The ADON told the inspectors that a recruitment campaign was ongoing and that they had been involved in activities in relation to this that day. They said that one permanent staff nurse had been appointed and was due to commence employment, however, recruitment remained challenging. In addition, they told the inspectors that due to the reduction in the number of residents at this designated centre that one staff nurse was sufficient at that time. This decision was supported by a skill mix review which took place recently. This review was an agreed action following the June 2022 inspection. The inspectors reviewed the template used to review and change the staffing arrangements. They found that although the template provided information on residents assessed needs, it did not provide systems to measure or analyse the skill mix required to meet with these assessed needs. In addition, there was no evidence available to show who completed the review as it was not signed or dated. This required review. As part of the inspection process, the inspectors met and spoke with four of the staff on duty. Staff spoken with expressed concern in relation to a shortage of staff including nurses. They said that this impacted the lived experience

of four residents with epilepsy as they were not able to leave the designated centre without a staff nurse. They said that there was a plan in place to upskill staff members so that they would have the knowledge and skills to meet with the needs of all residents, however, there was no date agreed and this remained outstanding. This matter was also documented on the minutes of governance meeting in November 2022 where staff raised concerns in relation to residents' inability to attend appointments or attend family events due to staff shortages.

A review of the governance and management arrangements in place found that the provider failed to ensure that the designated centre was resourced to ensure the effective delivery of care and support for the residents. This was due to the fact that the shortage of nurses on duty impacted on the day to day lives of some of the residents and therefore an equitable experience was not provided for all. Furthermore, due to ongoing changes in staffing and as previously outlined in the June 2022 report, the provider failed to provide a consistently safe service. The inspectors found that no improvements were made since this time. In addition, although there was a management structure in place, it was changing and not clearly defined. For example, the CNM1 position remained vacant and the staff nurse on duty was unsure of who was providing cover on the first day of inspection. The staff member that arrived was unsure of the arrangements in place and was not on the roster, as it was not their designated centre. Therefore, the lines of authority and responsibility lacked clarity.

A review of the auditing systems used found that the annual review of quality and safety of care was completed. This appears to have been completed in quarter 3, however, no date was provided on the copy given to the inspectors. The provider-led six monthly audit was completed in December 2022. Although actions were agreed as part of this process, there was no timeframe provided. There was a quality improvement plan in place and this was reviewed and updated recently. This included an action in relation to the resumption of day services, however, the action documented related to a meeting due to take place in April 2022. Therefore this action was out of date. Furthermore, the action in relation to the provision of adequate staffing and appropriate skills mix was documented as completed. This did not align with the findings on inspection.

A review of the documentation used and the records in place was carried out by the inspectors. This included an assessment of residents care plans, nursing interventions, positive behaviour support plans, risk assessment and multi-disciplinary (MDT) reports and recommendations. The inspectors found that while there was some useful and relevant information available, it was difficult to find. The folders provided were cumbersome and in some cases, the information provided dated back to 2014 and was not relevant to the residents' current needs. Furthermore, where up-to-date and relevant information was provided this was not always available to guide staff. For example, a recent feeding, eating and drinking assessment was completed for one resident. However, the information available to guide staff which was kept in the dining room was not updated. The old information remained. This meant that the staff on duty did not have access to the correct information at all times and this posed a significant risk. Furthermore, both expired assessments and up-to-date assessment were filed in the resident's main folder and

this lead to a mix of information and a lack of clarity. Also, the inspector found that some residents had a comprehensive review of their communication needs which was completed by the speech and language therapist (SALT) and that this contained a recommendation on the use of 'objects of reference' to assist residents to communicate. However, these were not in use on the days of inspection. The inspectors noted that this matter was raised by the SALT at a meeting in August 2022 where they said that they wished to meet with staff, however this was difficult to organises due to staff shortages. Therefore, the inspectors found the governance, management and oversight of the systems and processes in place was not working. An urgent compliance response in relation to the risks identified was issued and this will be expanded on later in this report.

The inspector reviewed the incident management system used in the centre and cross referenced this to the provider-led six monthly audit referred to above. This audit noted that no accidents or incident audits were completed during the period of August – November 2022 and a retrospective audit for this void was required. This was to be completed by the person in charge, however, no due date was provided. In addition, the inspectors found that monitoring notifications were not reported to the Chief Inspector in accordance with the requirements of regulation 31. For example, an incident that occurred in October 2022 in relation to safeguarding and protection of residents was not reported within the timeframe specified and there was a delay of 10 days between the occurrence and the subsequent reporting to the Chief Inspector. This was discussed with the ADON who explained that the person in charge had access to HIQA's reporting portal and that when they were on leave there was no back up plan in place at that time. This arrangement required review.

The next section of this report will describe the care and support that people receive and if it was of good quality and ensured that people were safe.

Regulation 15: Staffing

The registered provider was unable to ensure that a sustainable number and skill mix of staff which was appropriate to the number and assessed needs of residents was provided. Areas identified that required improvement included:

- the ability of the provider to ensure that the designated centre had staffing resources to ensure the effective delivery of care and support for the residents.

Judgment: Not compliant

Regulation 23: Governance and management

A review of the governance and management arrangements in place found that the

provider failed to ensure that the designated centre was resourced to ensure the effective delivery of care and support for the residents. Areas identified that required improvement included:

- the ability of the provider to ensure that the designated centre had staffing resources to ensure the effective delivery of care and support for the residents.
- the ability of the provider to provide a consistently safe service
- to ensure that adequate management supports are in place in accordance with the roster provided
- to ensure that the annual review and provider-led audits are completed as required
- to ensure that the quality improvement plan is up-to-date and that actions are recorded correctly
- to ensure that the residents' records and staff guidance provided is clear, comprehensive, up-to-date and easily accessible
- to ensure that all actions identified on inspection are addressed in line with the providers commitment through their compliance plan submitted

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which was amended on the day of inspection to ensure that it contained the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that monitoring notifications were reported to the Chief Inspector in a timely manner and in accordance with the requirements of the regulation. For example; safeguarding notifications.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider has a range of policies, procedures and guidelines which were available

and accessible for staff's use. Although some had been updated since the last inspection, the following policy required attention:

- the policy and procedure on restrictive practices had not been reviewed during the past three years.

Judgment: Substantially compliant

Quality and safety

In general, the residents living at this designated centre received a good level of care and support from the staff on duty. They were facilitated to attend appointments with their general practitioner (GP) and members of the multi-disciplinary team were involved in their circle of support. However, the inspectors found that the recent changes in management and leadership roles and the ongoing changes in the staff team impacted on the quality and safety of the service provided and improvements were required in a number of areas which will be outlined throughout this report.

Most residents that required support with behaviours of concern had positive behaviour support plans available and staff spoken with told the inspector that they had training in positive behaviour support. There was evidence of MDT involvement, including the speech and language therapist and the psychologist, in the development of the behaviour support plans. However, one resident who recently displayed responsive behaviours did not have a positive behaviour support plan in place and this required review. Restrictive practices were in use in this centre. However, as previously referred to the restrictive practices policy was out of date as it had not been reviewed in the previous 3 years. While a log of restrictive practices was maintained, staff were not recognising that holding a residents hands under a pillow was a restrictive measure. Consequently, there was no support plan in place with regard to the rationale for doing this and what benefit, if any, it was for the resident. In addition, there was no evident that it complied with national policy and evidence based practice, in that it was the least restrictive measure for the shortest period of time.

The inspectors found that improvements were required in the systems used to ensure that residents were safeguarded and protected from abuse. The provider had a local safeguarding and protection policy in place. The inspectors found that his required review as the designated officer identified was not working in the service at that time. In addition, a member of staff spoken with was not aware of the identity of the designated officer. Furthermore, three staff members required training in safeguarding and protection. The safeguarding and protection plans for the service were reviewed. The inspectors found that the staff on duty were unsure of the number of plans in place and mixed messages were provided in this regard. The documentation in place showed that there was one open safeguarding and

protection plan and that this was ongoing. As referred to previously, an incident of concern occurred in October 2022. However, this was not immediately recognised as a safeguarding concern at that time and there was a delay of 10 days until this incident was reported to the Chief Inspector and to the HSE Safeguarding and Protection Team. In addition, a previous serious safeguarding and protection concern occurred in January 2022. This appeared to occur over two days. However, it was unclear whether the concern was acknowledged as a safeguarding concern and reported on the first day that it was witnessed, or not.

While staff spoke of residents' rights being protected in the centre it was difficult to see the voice of the resident in the daily operation of the centre and with regard to decisions made. For example, a piece of furniture for a resident's bedroom was purchased. This was paid for by the resident and recorded in their personal property log. Despite this, it was difficult to see how the resident was involved in the decision to purchase and pay for this as it was of enhanced quality and therefore of additional cost. There was no policy available in the centre on the management on residents' personal finances. In addition, it was agreed that some residents would benefit from a return to day service and although the previous person in charge had advocated on the residents' behalf this was not actioned to date. Furthermore, the inspectors found that the arrangements in place for the provision of meals required reviewed. Meals were delivered from a centralised kitchen and nutritious choices were offered. However, the three main meals of breakfast, dinner and tea were delivered within 7.5 hours. Consequently, residents were relying on snacks for 16.5 hours per day. Snacks were available at 19:00 hrs and 21:00hrs. 'Ready brek' or 'custard was used for snacks for some residents in the centre and while inspectors acknowledged that this may be the residents preferred choice, the age appropriateness of these practices required consideration. Furthermore, a kitchenette was available for this purpose, however this was locked. Staff told the inspectors that this was as a result of infection prevention and control procedures and for resident's safety. However in discussion with the person in charge she stated that the kitchenette could be unlocked for periods and any risk posed to residents could be managed by staff supervision. The ADON agreed to review the practices in relation to meal times, the locking of the kitchenette and the provision of snacks as a matter of priority

As previously outlined, the speech and language therapist had developed a communication system based on 'objects of reference' and a report recommending its usefulness was available. An object of reference is an object which has a particular meaning associated with it. For example, a scented shampoo may be used as an object of reference for bath/shower time. These objects need to be used consistently to give the resident information about what is going to happen and can be used to support the development of the residents understanding. Inspectors observed that this communication system was not in use in the centre on the days of inspection and staff spoken with confirmed that this they did not consistently use this system.

While Residents' meetings took place there was no evidence of engagement of the residents. No advocacy services were attending the centre and there was no human rights committee in place. The person in charge had referred residents to the

national advocacy service in April 2022 but there was no follow up in regard to this communication. As part of the provider's compliance plan submitted following the June inspection, human rights committee meetings were referenced as taking place on a monthly basis. Minutes of these meetings were available. However, the inspectors found that these were held at 'county level' and the person in charge or the ADON did not attend.

As referred to earlier in this report, and in the findings from the previous inspection report, residents had not returned to their day services. Activities were facilitated from the residential service and an activities co-ordinator was in post. This was discussed with the person in charge who told the inspector that that some residents would benefit from the opportunity to return to their day service. Staff spoken with agreed that residents benefited from this service in the past and it was noted that the previous person in charge had escalated this concern prior to their leave. However, the provider had failed to adhere to the action plan submitted and by the date agreed as the recruitment campaign was ongoing and the day service remained closed. Furthermore, the concerns identified in relation to shortage of nursing staff to accompany residents on outings and to support them with their nursing needs had not been addressed. This required review.

As outlined, this designated centre was located in an institutional setting. A de-congregation plan was in progress with a completion date of 31st December 2023. The inspectors reviewed a sample of six minutes of the monthly de-congregation meetings held. The inspector found that in general, they were well attended by the members of the group as outlined on the June 2022 compliance plan. However, representatives from the estates department appeared to attend on two occasions out of the six reviewed. The service provided had changed since the last inspection and the number of residents was reduced to nine. This meant that there were two single occupancy rooms available for use by the residents currently using the dormitory accommodation. The ADON and the staff team spoke with the inspector about the plans that were in place to enhance the residents sleeping arrangements and to provide additional privacy. However, the plans were not actioned and they remained outstanding despite the passage of time. This meant that some residents continued to share dormitory sleeping accommodation with some distance to the closest toilet facilities. This meant that residents were at risk of disturbed sleep, lack of privacy and dignity and no private space for storage of their personal possessions.

There were systems and procedures in place for risk assessment and risk management. Risks impacting on residents were rated and escalated by the person in charge. These included a risk assessment on nursing staff shortage and a risk assessment on the lack of provision of day service for residents. Although these risks continued to be highlighted there was no improvements noted. Residents had individual risk assessments if required. For example, one resident had a risk assessment in relation to behaviours that could result in self-injury. This had been recently updated in relation to a medical assessment and the actions arising from this. However, as previously referred, the inspectors noted that when this behaviour occurred, the staff providing support would hold the resident's hands under a pillow.

This was not referred to a control measure on the risk assessment.

In addition, it was noted that all staff carried a personal alarm when on duty. Staff members spoken with told the inspectors that they required these alarms to alert nursing staff if a resident had a seizure. Inspectors noted that when this practice was enacted during the inspection that it was reactive in nature. It did not support a person centred homely environment. There was no risk assessment in place with regard to the use of these alarms and no rationale for their use as a risk control measure. This required review.

As referred to previously in this report, the inspectors had significant concern in relation to the practices in place to support residents with feeding, eating and drinking (FEDS). One resident had a choking incident in July 2022 and they were assessed by a speech and language therapist (SALT) in August 2022. Guidelines were provided which specified risks associated with the resident over-loading their mouth and the SALT recommended a specific level minced diet. However, the inspectors found that the information provided to guide staff had different guidance from that provided by the SALT. Secondly, another resident had an identified risk of choking and the requirement to have 1:1 support while eating and drinking was recommended by the SALT. The inspectors found that the 'personal place mat' system used to guide staff was not updated with the most recent assessment information and did not refer to the requirement for 1:1 support. A third resident had a swallowing assessment completed in August 2022 and updated guidance was provided by the SALT. However, the guidance on the personal place mat system was not updated and referred to guidelines dated June 2021 and from a previous speech and language therapy assessment. This was out of date. In addition, the newest guidance recommended that the resident eat while in an upright position which was to be maintained for a period of 30 minutes after their meal. However, the guidance provided for staff recommended that breakfast be served in bed. An urgent compliance request in relation to these concerns was issued to the provider on the second day of inspection in this regard.

Furthermore, during the course of inspection, it was noted that all staff carried a personal alarm when on duty. There was no risk assessment in place with regard to the use of these alarms. Staff stated that they required these alarms to alert nursing staff if a resident had a seizure. Inspectors noted that when this practice was enacted during the inspection that practice was reactive in nature and did not support the quiet enjoyment of a person centred homely environment.

The provider had a fire safety management plan to ensure that residents could be safely evacuated in the event of a fire emergency. All residents were accommodated on the ground floor. Personal evacuation plans were in place for all residents. Regular fire drills were being completed. All staff spoken with displayed good knowledge of how they would evacuate if a fire occurred. Staff training records confirmed that fire training had been offered to staff. Staff who had recently been appointed and had not completed formal fire training had completed training bespoke to the centre. Directions for calling the fire brigade was available beside the telephone.

In summary, this inspection found a number of concerns in relation to the welfare of the residents and the safety of the service provided. An urgent compliance request was issued in relation to the management of risks identified in relation to feeding, eating and drinking. In addition actions were required in the oversight of the schedule 5 policies in place, the staffing levels provided, the submission of notifications, positive behaviour support plans, safeguarding, rights, general welfare and the premises provided.

Regulation 13: General welfare and development

Residents at this designated centre had not returned to their day services. Due to the fact that an activities co-ordinator was in post there were some activities taking place. The following areas required improvement:

- to ensure that all residents had the support of appropriately qualified staff to support their access to community based activities in accordance with their interests, capacities and developmental needs.
- to ensure that residents had access to a day service if appropriate

Judgment: Substantially compliant

Regulation 17: Premises

A de-congregation plan was in progress for this designated centre. However, the inspectors found that the design of the premises remained unsuitable for the needs of the residents. Areas identified that required improvement included:

- the use of shared dormitory accommodation for residents

Judgment: Not compliant

Regulation 26: Risk management procedures

There provider did not ensure that the systems in place for the assessment, management and ongoing review of risk were effective. Areas identified that required improvement included:

- to ensure that risks identified were clearly identified, communicated to all staff and that information on the control measures was clear and accessible
- to ensure that escalated risks previously raised by the person in charge were addressed and improvements made

- to ensure that all risks were identified and that control measures were recorded as such

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had a fire safety management plan to ensure that residents could be safely evacuated in the event of a fire or emergency. Personal evacuation plans were in place for all residents. Regular fire drills were being completed. All staff displayed good knowledge of how they would evacuate if a fire occurred. and fire training was up to date.

Judgment: Compliant

Regulation 7: Positive behavioural support

Most residents that required support with behaviours of concern had positive behaviour support plans available and staff spoken with told the inspector that they had training in positive behaviour support. Areas identified that required improvement included:

- to ensure that all residents that displayed responsive behaviours had a positive behaviour support plan in place
- to ensure that the policy on the restrictive practices was up to date.
- to ensure that all restrictions were recognised as such and recorded on the restrictive practice log
- to ensure that all restrictions complied with national policy and were the least restrictive measure for the shortest period of time

Judgment: Substantially compliant

Regulation 8: Protection

The provider had not ensured that all residents were safeguarded and protected from abuse. Areas identified that required improvement included:

- to ensure that the safeguarding and protection policy was updated to include reference to the current designated officer
- to ensure that all staff had training in safeguarding and protection and are

aware of the identify of the designated officer
- to ensure that all staff were aware of the number of open safeguarding and protection plans in place and the actions required to safeguard residents
- to ensure that all concerns were identified, addressed and reported in a timely fashion

Judgment: Not compliant

Regulation 9: Residents' rights

The provider did not ensure that residents participated in and consented to supports and decisions about their care and support. Access to advocacy services was not provided. Areas identified that required improvement included:

- to ensure that residents had access to the kitchenette and access to food and drinks when the main kitchen was closed
- to ensure that residents were involved in decisions about personal purchases made on their behalf
- to ensure that the residents wishes to return to their day service was supported
- to ensure that residents had access to meals throughout the day and in line with the norms of a typical home environment
- to ensure that residents had access to advocacy services

Judgment: Not 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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for James Connolly Memorial Residential Unit OSV-0002502

Inspection ID: MON-0037815

Date of inspection: 07/12/2022 and 08/12/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: - The Person in Charge in liaison with the Assistant Director of Nursing have completed a review of the staff Rota and staffing requirements – Date completed 16/01/23 - The Person in Charge will ensure that there is a Rota in place that ensures the effective delivery of care and support for the residents in line with the centres Statement of Purpose – Date for completion 06/03/23 - The Person in Charge has ensured that all staff are made aware of the reporting structure when they are on leave. This is communicated via a memo and it is documented in the staff communication book – Date completed 08/12/22 - The CNMI for will be returning to their substantive in post on 26/02/23 and this will comply with the agreed governance structures – Date for completion 26/02/23 - There has been a recruitment campaign for an additional 2 staff nurses and they are in post since 16/01/23 – Date completed 16/01/23 - There has been a recruitment campaign for 5 care staff, 4 have commenced their posts and 1 is in the process of completing clearance. – Date for completion 06/03/23 - The Person in Charge will continue to review the Rota on a daily and weekly basis – Date completed 08/12/23	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge in liaison with the Assistant Director of Nursing have completed a review of the staff Rota and staffing requirements – Date completed 16/01/23 • The Person in Charge in liaison with the Assistant Director of Nursing has completed a review of the skill mix required to meet the assessed needs of the residents and they have ensured that this template is dated and signed by the parties that have completed it. – Date completed 16/01/23 • The Person in Charge will ensure that there is a Rota in place that ensures the effective	

delivery of care and support for the residents in line with the centres Statement of Purpose – Date for completion 06/03/23
• The Person in Charge has ensured that all staff are made aware of the reporting structure when they are on leave. This is communicated via a memo and it is documented in the staff communication book – Date completed 08/12/22
• The Person in Charge will reissue the governance structure template and will have this as an agenda item for the next staff governance meeting – Date for completion 31/01/23
• The CNMI will be returning to their substantive in post on 26/02/23 and this will comply with the agreed governance structures – Date for completion 26/02/23
• There has been a recruitment campaign for an additional 2 staff nurses and they are in post since 16/01/23 – Date completed 16/01/23
• There has been a recruitment campaign for 5 care staff, 4 have commenced their posts and 1 is in the process of completing clearance – Date for completion 06/03/23
• The Person in Charge will continue to review the Rota on a daily and weekly basis – Date completed 08/12/23
• An on call system is in place to ensure effective governance is provided at weekends and evenings from 5pm to 9am. This is updated regularly and communicated to all staff.- Date completed 08/12/22
• The provider will ensure that all actions identified from the 6 monthly unannounced visits and the centres annual review will be clearly added to the centres QIP with identified timeframes for close out – Date completed 31/12/22
• The provider will ensure that the 6 monthly unannounced visits and the annual review are clearly dated and the name of the person completing the visit is included on the report – Date completed 31/12/22
• The Person in Charge and Assistant Director of Nursing will ensure that the centres QIP is reviewed weekly and that all actions from audits are included on the QIP and that it is an accurate reflection of the current status of each action within the centre – Date completed 15/12/22
• The Speech & Language Therapists recommendations have been clearly communicated to staff and are being strictly implemented. – Date completed 08/12/22
• The Person in Charge has ensured that the Speech & Language Therapists interventions with Objects of Reference communication boxes have been re-introduced and implemented as a communication tool for individual residents as a part off their daily routines. The Registered Nurses will oversee their implementation.
• The Person in Charge has reviewed all resident's files in conjunction with the named nurses. All out of date information has been removed and archived and files now follow the agreed Donegal Disability Services index/contents sheet. Date completed 25/01/23
• The Person in Charge in conjunction with named nurses, have reviewed and updated all residents individual risk assessments within their care plan. Date completed 25/01/23
• The Person in Charge has commenced a full audit of the care plans for all residents in the centre. An action plan has been developed to update all the records to ensure that they provide clear, comprehensive guidance to staff in relation to the care and support that is to be provided to residents. To date 4 of the 9 care plans have been audited – Date for completion 31/01/23
• The Person in Charge will liaise with the speech and language therapist to provide additional sessions with staff to revisit the recommendations currently in place – Date for completion 28/02/23
• The Person in Charge has completed a retrospective audit of the accidents and incidents within the centre from August to December 2022 – Date completed 26/12/22

• The Person in Charge will continue to complete audits in line with the agreed CHO1 revised audit schedule.– Date completed 31/12/22 • The Person in Charge will ensure that all notifications are submitted to the regulator within the required timeframes – Date completed 31/01/23 • The Person in Charge has arrangements in place for notifications to be submitted in the absence of the Person in Charge – Date completed 31/12/22 • The Donegal Human Rights committee meet bi monthly and there is a Director of Nursing representative on this forum. Minutes are circulated to all services. The Person in Charge will ensure that these minutes are available to staff to read – Date for completion 28/02/23 • The Person in Charge will review the centres training matrix on a monthly basis to ensure that staff have completed all mandatory training and schedule any outstanding training – Date completed 31/12/22 • The Person in Charge will schedule staff for any training that is outstanding with an emphasis on fire training for new staff – Date completed 25/01/23

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • The Person in Charge will ensure that all notifications are submitted to the regulator within the required timeframes – Date for completion 31/01/23 • The Person in Charge has arrangements in place for notifications to be submitted in the absence of the Person in Charge – Date for completion 31/12/22 • The Person in Charge will ensure that all restrictive practices within the centre are reported on the quarterly notifications to the regulator – Date for completion 31/01/23	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • The Person in Charge has reviewed all policy documents and ensured that the most up to date policies and procedures are available to guide staff with particular reference to the restrictive practices policy – Date completed 14/12/22 • The Person in Charge has reviewed all policy documents and ensured that the Policy on the Management of Residents Finances is available to guide staff – Date completed 14/12/22 • The Person in Charge will ensure that staff sign off on all updated policies and procedures – Date for completion 31/01/23	
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 ensure that there is a Rota in place that ensures the effective delivery of care and support for the residents with an emphasis on activities – Date for completion 06/03/23	

• The Person in Charge will continue to review the Rota on a daily and weekly basis – Date completed 08/12/22 • The centre has an activity coordinator in place to ensure that residents are supported to access activities within the local community and plan social activities – Date completed 01/01/22 • The Person in Charge in liaison with the Assistant Director of Nursing and the resident and/or their representative will complete a review of their requirements for an external day service placement – Date for completion 28/02/23

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The Person in Charge in conjunction with the multi-disciplinary team has reviewed the shared dormitory accommodation and 2 residents were identified to relocate to single occupancy bedrooms. Two residents have relocated and there remains 7 residents in the shared dormitory – Date completed 20/12/22 • A decongregation plan has been developed for this centre which is due to be completed by 31/12/23. An update has been submitted to the regulator on 25/01/23 – Date for completion 31/12/23	

Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The Person in Charge has reviewed all restrictive practices in use within the centre with particular emphasis on the restrictive practices of holding a residents hand and the use of personal alarms. The outcome of this review has been communicated to all staff – Date completed 25/01/23 • The Person in Charge has reviewed all risks within the centre to ensure that all risks are identified and that control measures in place are adequate to mitigate against the risk identified. Any risks that cannot be managed at centre level have been escalated to the Disability Manager – Date completed 15/12/22 • The Person in Charge completes a review of all risk assessments on a quarterly basis or sooner if required – Date completed 31/01/23 • The Person in Charge has reviewed all policy documents and ensured that the most up to date policies and procedures are available to guide staff with particular reference to the restrictive practices policy – Date completed 20/1/2023	

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 has in conjunction with the MDT to include the clinical psychologist have reviewed the requirement for residents to have a Behaviour support plan in place. Where there is a requirement for a behaviour support plan to guide staff this is in place. – Date for completion 31/01/23 • The Person in Charge has reviewed all policy documents and ensured that the most up	

to date policies and procedures are available to guide staff with particular reference to the restrictive practices policy – Date completed 14/12/22
• The Person in Charge has completed a review of the restrictive practices to ensure that they are in line with the national policy in relation to being the least restrictive practice for the shortest duration– Date for completion 15/12/22
• The Person in Charge will ensure that restrictive practices is a standing agenda item at staff governance meetings – Date for completion 31/01/23
• All staff will update their training in relation to restrictive practices to ensure that they are aware of what constitutes a restrictive practice – Date for completion 28/02/23
• The Person in Charge has reviewed the restrictive practice log to ensure that it is accurate and reflective of all restrictive practices in use within the centre – Date completed 31/12/22
• The Person in Charge will complete the audits of restrictive practices in line with the agreed CHO1 revised annual audit schedule – Date completed 25/01/23

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Donegal Disability Services Safeguarding policy has been reissued to staff to read and sign off on – Date for completion 31/01/23
• The Person in Charge will ensure that any safeguarding incidents are identified, addressed and reported in a timely manner in line with the timeframes set out in the Donegal Disability Services Safeguarding policy the regulatory requirements – Date completed 31/12/22
• The Person in Charge has updated the local safeguarding guidelines to ensure it is reflective of the current practices and clearly identifies the local designated officers.- Date completed 25/01/23
• Designated officers information is on display within the centre – Date completed 25/01/23
• The Person in Charge has advised staff that require to complete/refresh their safeguarding training to do so on HSELand and this will be monitored weekly by the Person in Charge via the training matrix. - Date for completion 3/02/23
• The Person in Charge will discuss open safeguarding incidents at staff governance meeting and ensure that safeguarding is a standing agenda item on same. Date for completion 31/01/23

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Person in Charge has completed a risk assessment in relation to the kitchen door being open – Date for completion 31/01/23
• The Person in Charge has commenced a review of the arrangements for resident's access to the kitchenette, food and drink when the main kitchen is closed. – Date for completion 31/01/23
• The Person in Charge will liaise with the MDT, including the dietician to review the meals and options provided to residents – Date for completion 28/02/23
• The Person in Charge in liaison with the Assistant Director of nursing and the resident and or their representative will complete a review of the residents requirements for an external day service placement – Date for completion 28/02/23

• The Person in Charge has contacted the National Advocacy Service for an update in relation to the referrals previously submitted for residents. A representative will be calling to the centre on 23/02/23 – Date for completion 15/03/23
• Speech & Language Therapists recommendations have been clearly communicated to all staff and will be strictly implemented – Date completed 31/01/2023
• The Person in Charge has ensured that the Speech & Language Therapists interventions with Objects of Reference communication boxes have been re-introduced and implemented as a communication tool for individual residents as a part off their daily routines.
• The Person in Charge has reviewed all residents' files in conjunction with the named nurses. All out of date information has been removed and archived and files now, follow the agreed Donegal Disability Services index/contents sheet. Date completed 25/01/23
• The Person in Charge has advised staff that they require to complete consent training on HSELAND to complete this – Date for completion 14/02/23
• The Person in Charge are currently seeking person centred planning training for staff working within the centre – Date for completion 31/06/23
• The Person in Charge will ensure that the financial policy is strictly adhered to in relation to any purchases. Date for completion 15/03/23

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Substantially Compliant	Yellow	06/03/2023
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	06/03/2023
Regulation	The registered	Not Compliant	Orange	31/12/2023

17(1)(a)	provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	06/03/2023
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	06/03/2023
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'	Not Compliant	Orange	06/03/2023

	needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/01/2023
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	31/01/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	14/02/2023
Regulation 07(1)	The person in	Substantially	Yellow	28/02/2023

	charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Compliant		
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	28/02/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	03/02/2023
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	15/03/2023
Regulation	The registered	Not Compliant	Orange	15/03/2023

09(2)(d)	provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	15/03/2023