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:	Dungloe Services
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	14 November 2022 and 15 November 2022
Centre ID:	OSV-0003331
Fieldwork ID:	MON-0032199

About the designated centre

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

Dungloe services provide full-time and part-time residential care and support to both male and female adults with a disability. Dungloe services comprises of two premises, which includes a bungalow located in a rural town and a two-storey house located on the outskirts of the same town. As well as their bedrooms, residents have access to communal facilities in each house which includes kitchen/dining rooms and sitting rooms, as well as bathroom and laundry facilities. Residents are supported by a team of both nursing and health care assistants and staffing levels are directed by residents' assessed needs. At night, residents are supported with sleepover staff, due to their assessed needs. In addition, there are arrangements in place to provide support outside of office hours, weekends and public holidays for staff, if required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 14 November 2022	14:30hrs to 19:30hrs	Catherine Glynn	Lead
Tuesday 15 November 2022	09:00hrs to 14:30hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

This centre is run by the Health Service Executive (HSE) in Community Healthcare Organisation Area 1 (CHO1). Due to concerns about the management of safeguarding concerns and overall governance and oversight of HSE centres in Co.Donegal, The Chief Inspector undertook a review of all HSE centres in that county, including a targeted inspection programme which took place over two weeks in January 2022 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection) and regulation 23 (Governance and Management). The overview report of this review has been published on the HIQA website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors are now completing a programme of inspections to verify whether the actions have been implemented as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co.Donegal.

At the time of the inspection the provider had implemented a number of actions to strengthen the governance and management. In addition, a number of actions relating to positive behaviour support (regulation 7) and protection (regulation 8) had been completed or were in progress. These will be discussed in the other sections of this report.

This inspection was unannounced and was carried out to monitor regulatory compliance in the centre. As part of this inspection, the inspector observed the care and support interactions between residents and staff. The inspector met with residents who lived in this centre, spoke with staff on duty, and also viewed a range of documentation and process.

The centre consisted of two houses and provided full-time residential care to eight adults. At the time of the inspection there was six people living in the centre.

The centre suited the needs of residents and provided them with a safe and comfortable living environment. Both houses were located on the outskirts of a residential area in Donegal town. This gave residents good access to a wide range of facilities and amenities. Both houses were clean, bright, suitably furnished- and decorated, and there was adequate communal and private space for residents. All residents had their own bedrooms and had the use of sitting room, kitchen and dining area, and an appropriate laundry area. Each house had gardens to the front and rear of the centre, which provided additional outdoor space. One house was relocating to a purpose build faciility in the town and residents were awaiting an update for this move at the time of the inspection.

The inspector met all six residents at times during the inspection, and saw how they spent their time, and observed interactions between residents and staff. All of the

residents were happy to communicate in their preferred manner, three residents spoke with the inspector about the support they received and that they were happy with the service provided to them. One resident enjoyed a bespoke day service model and was supported to complete their morning activities in a relaxed manner before going on a planned outing. Overall, all residents spoken with enjoyed living in this centre and some residents were also looking forward to a planned move into a purpose build facility.

All six residents were observed at ease and comfortable in the company of staff, and were relaxed and happy on the centre. Throughout the inspection, staff were observed spending time and interacting warmly with residents, supporting their wishes, ensuring that they were doing things that they enjoyed and providing meals and refreshments their needs and preferences. Staff members who spoke with the inspector were focused on ensuring that residents were supported in line with their assessed needs. In addition, staff spoken with were very aware of resident on needs and preferences. The inspector also observed a wide range of communication aids in use for residents to express their views.

On the first evening of the inspection, residents had returned from day services and were preparing their evening meals and snacks. Staff members who spoke with the inspector were focused on supporting the residents, monitoring the wellbeing of all residents and their transition into the centre after their busy day. The inspector also met with the clinical nurse manager allocated to this centre as the person in charge was on leave at the time of this inspection. It was clear that the staff and management team were all clear on their roles and responsibilities in this centre and they ensured that they communicated effectively to promote a safe service.

Measures remained in place to ensure that the risk of COVID-19 infection for residents was reduced. Hand sanitisers were available through both houses, and masks and thermometers were available for use as required. Information about infection control was displayed throughout the centre to inform residents, staff and visitors to the centre.

Overall, it was evident from observation in the centre, conversations with staff, and information viewed during the inspection, that residents had a good quality of life, had choices in their daily views, and were supported by staff to be involved in activities that they enjoyed, both in the centre, at day services and in the local community. Throughout the inspection it was clear that the management team and staff prioritised the wellbeing and quality of life of residents.

The inspector found that that this inspection identified good practices throughout the regulations that were reviewed, there were some minor areas for improvement, which will be discussed in the next section of this report.

Capacity and capability

The provider had measures in place to ensure that this centre was well managed, and that residents' care and support was delivered to a high standard. These arrangements ensured that a good quality and safe service was provided to the residents who lived there.

The provider had submitted a compliance plan in response to the findings from some targeted inspections in January 2022. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in the centre, These included the introduction of regular meetings within the centre and across the service in the county. The lead staff on duty discussed how the compliance plan was being implemented and showed the inspector documentation and improved systems that had been introduced as part of this plan.

There was a clear organisational structure in place to manage the centre. There was a suitably qualified and experienced person in charge. The person in charge was based in an office in close proximity to the houses. While the person in charge was on leave at the time of this inspection, staff spoken with were familiar with the person in charge as well as the residents spoken with. The inspector found that the person in charge had ensured that clear arrangements in place to support staff and to access support of senior managers when the person in charge was not on duty, as found on the day of this inspection.

Since the previous inspection in January 2022, significant improvement to the overall organisational management processes had taken place. These improvements included a range of governance and oversight meetings. For example, human rights committee meetings were being held quarterly and weekly regulation, monitoring and governance meetings also took place. The person in charge also spoke about attending fortnightly meetings with other persons in charge, and how these meetings were a useful forum for receiving information from both their peers and senior management, as well as an opportunity for shared learning with other persons in charge, and sometimes presentations from external guest speakers.

There were strong systems in place for reviewing and monitoring the service to ensure a high standard of safety and care was provided and maintained. Unannounced audits of the service were being carried out on behalf of the provider. These were being carried out twice each year and identified any areas where improvements were required, with action plans developed to address these issues. A detailed and relevant audit plan for 2022 had been developed which included a range of comprehensive audits to review the overall quality of care and safety in the centre. The person in charge and staff were completing these audits in line with this plan. These included monthly audits of fire safety, personal planning, infection control, complaints, incidents and medication, The sample of audits that the inspector viewed reflected a high level of compliance and actions arising had been completed as required. The provider also carried out a comprehensive annual review of the service which met the requirements of the regulations.

A quality improvement plan had been developed by the person in charge and management team, which was informed by the completed audits , six-monthly provider audit outcomes, the annual review, inspections by the health information and quality authority, and various self-assessments processes. The quality improvement plan was used as a basis for ongoing improvements in the centre. It identified areas for improvement, time frames for completion of improvement works, and a record of when the required work had been finalised. The quality improvement plan was reviewed and updated monthly, and the October 2022 plan showed that all current works had been completed or were in progress within the required time frames.

The centre was suitably resourced to ensure the effective delivery of care and support to residents. These resources included the provision of suitable, safe, clean and comfortable environment, and adequate staffing levels to support residents om both their leisure and healthcare needs, and a transport vehicle dedicated to the centre. A range of healthcare professionals, including nursing, speech and language therapy, physiotherapy and behaviour support staff were available to support residents where required.The provider had also ensured that transition planning was in place as part of the reconfiguration of this service. The centre was also resourced with many physical facilities to reduce the risk of spread of infection. These included hand sanitising gels, supplies of disposable gloves, face masks and aprons, cleaning materials and thermometers.

Staffing levels and skill-mixes were sufficient to meet the assessed needs of residents at the time of inspection, with a nursing and care staff available to support residents at all times. Planned staffing rosters had been developed by the person in charge. These were updated to reflect the actual arrangements as required and were accurate on the day of inspection.

Training had been provided to staff to enable them to carry out their roles effectively, A training needs analysis had been carried out to inform the training plan for the centre for 2022, and staff training was arranged accordingly, Much of the planned training was focused on enhancing safety and welfare of residents in this centre. Staff had received mandatory training in fire safety, behaviour support and safeguarding, in addition to other relevant training such as open disclosure, the national consent policy, cyber security awareness and data protection. The inspector found that some staff required additional support from the management team to ensure the completion of training provide through online methods.

There were good measures in place for the management of complaints. These included an easy-to-read complaints process that was accessible to residents and a clear system for recording and investigating complaints. On reviewing the management of complaints that had been made, the inspector found that these had been managed appropriately by the management team, were investigated and documented, and that satisfaction of the person who made the complaint was recorded where required. A new complaints policy had been developed which was informative, however it required further review on the appeals process.

Regulation 15: Staffing

Staffing levels and skill-mixes were sufficient to meet the assessed needs of residents at the time of the inspection. Planned staffing rosters had been developed by the person in charge and these were accurate at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

While staff who worked in the centre had received mandatory training in fire safety, behaviour support, manual handling and safeguarding, in addition to other training relevant to their roles. The inspector found that one staff was awaiting completion of their training at the time of inspection, this staff had completed all face to face training but had not completed all of the online requirements. The nurse in charge advised the inspector that IT support was being provided to assist this staff in completing all outstanding training at the time of the inspection. There was a training schedule in place to ensure that training was delivered as required.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre showed that effective leadership and management arrangements were in place to govern the centre and to ensure the provision of a good quality and safe service to residents.

In response to the targeted safeguarding inspection programme, the provider had committed , through its compliance plan, to complete 11 actions aimed at improving governance arrangements at the centre. During this inspection, it was found that all 11 actions had been completed. For example, the provider had established a range of governance meetings which were attended by persons in charge and senior managers, and minutes from governance, quality and safeguarding meetings were being circulated to persons in charge to inform staff practice and to support the person in charge to introduce agreed actions in the centre. Furthermore, management audits had recently been reviewed to ensure that all aspects of the care and support provided to residents were being effectively monitored. During this inspection, it was found that a comprehensive range of audits were being carried out to review the quality of the service and to inform improvements to the service as required.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had ensured that systems were in place for reporting of all notifiable events to the Chief Inspector of Social Services as required by the regulations. The management team were aware of these requirements and relative events had been reported accordingly.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. Any complaints received in the centre had been suitably managed, investigated and recorded. There was an informative complaints policy, which had recently been updated. However, the policy and procedure did not provide sufficient guidance on the provider's appeals process, or how the complainant would be informed if the appeals process.

Judgment: Substantially compliant

Quality and safety

The provider had good measures in place in this centre to ensure that the wellbeing and health of residents was promoted and that residents were kept safe from risk, harm and infection. There was evidence that a good quality and safe service was being provided to residents. Since the last inspection of this service, the provider had introduced significant improvements to ensure that residents were being safeguarded from any form of harm, and overall these improvements were effective. However, improvement was required to some aspects of protecting residents from harm, as interventions which were in progress had not yet been completed.

The centre comprised of two detached houses on the outskirts of Dungloe, and were in close proximity to each other. The houses were close to local amenities such as shops, cafes,restaurants and other leisure amenities in the area. Each house had dedicated transport, which could be used for outings or any activities that residents chose. Some of the activities that residents enjoyed included outings to local places of interest, going out for coffee, housekeeping, listening to music or radio and watching television. The residents enjoyed walks and drives in the local area. The

staffing levels in the centre ensured that residents were supported to engage in activities of their choice of preference.

During a walk around of the centre the inspector found that it was comfortable, and was decorated and furnished in a manner that suited the needs and preferences of the people who lived there. The inspector saw some residents' bedrooms and these were personalised with family photos, art and personal items that the residents liked and enjoyed. The centre was kept in a clean and hygienic condition. Surfaces throughout the houses were clean and were well maintained. The centre was also very spacious with a variety of rooms where residents could spend time or carry out activities on their own.

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements relating to positive behaviour support at the centre. At the time of the inspection, the inspector found that all seven actions had been suitably completed. Improvements completed included staff training, familiarisation with behaviour support plans and site specific staff induction, Additional multidisciplinary team supports had been recruited and were working with residents.

Clear and detailed induction arrangements had been introduced for new staff. The person in charge and clinical nurse manager were knowledge on this process, although no recent recruitment had occurred at the centre. Previous induction records however were available for review during the inspection and completed by all current staff. The inspector found that staff had received detailed and appropriate induction on the care and support needs of residents to ensure that care would be delivered appropriately and consistently.

The provider had arrangements in place to safeguard residents from any form of harm. In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements relating to protection at the centre. At the time of inspection, the provider had completed 12 of these actions. The completed actions included a safeguarding tracker, relevant training for both the person in charge and staff, completion of a training needs analysis and development of a training schedule for staff and improvement to safeguarding auditing. The development of a policy on the provision of safe wifi usage had not yet been achieved, although the management team stated that this was in progress. At the time of this inspection, there were no safeguarding plans in place or compatibility issues reported in this centre.

Residents were supported to visit family and friends as they wished. Arrangements were also in place for residents to have visitors in the centre in line with latest public health guidance.

Regulation 17: Premises

The design and layout of the centre met the aims and objectives of the service, and the needs of residents. The inspector was advised during the inspection, that the provider had a plan in place to replace one house in this centre with a new purpose built facility located in the centre of the town by the end of the year.

Judgment: Compliant

Regulation 26: Risk management procedures

There were good risk management arrangements in the centre, which ensured that risks were identified, monitored and regularly reviewed. A wide range of risks and their control measures were included in the centre's risk register. The inspector noted that the risk of fire and safe evacuation had been assessed and included in the risk register for this centre.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had strong measures in place to ensure that the risk of infection in the centre was well managed. To ensure the safety of residents, staff and visitors, additional infection control procedures had been introduced in response to the COVID-19 pandemic.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Comprehensive assessment of the health, personal and social care needs of each resident had been carried out, and individualised personal plans had been developed for residents based on their assessed needs.

Judgment: Compliant

Regulation 6: Health care

The health needs of residents were assessed and they had good access to a range

of healthcare services, such as general practitioners, healthcare professionals and consultants. Plans of care for good health had been developed for residents based on each person's assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme and previous inspection of this centre in January 2022, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements relating to positive behavioural support at the centre. At the time of the inspection, the inspector found that all seven actions had been suitably completed.

The improvements which had been completed included staff training, familiarisation through behaviour plans and site specific staff induction. Additional multidisciplinary team supports had been recruited, were appointed, and were working with residents, while one post which had been approved and recruited was not yet in position but was sue to take up their role shortly.

Judgment: Compliant

Regulation 8: Protection

The provider had arrangements in place to safeguard residents from any form of harm. In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements relating to protection at the centre. At the time of inspection, the provider had commenced ad completed 12 of the actions.

The completed actions included development of a safeguarding tracker, relevant training for both the person in charge and staff, completion of a training needs analysis and development of a training schedule for staff and improvement to safeguarding auditing. The development of a policy on the provision of safe wi-fi usage had not yet been achieved, although the management team stated that this was in progress.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	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

Compliance Plan for Dungloe Services OSV-0003331

Inspection ID: MON-0032199

Date of inspection: 14/11/2022 and 15/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with Regulation 16 the following actions have been or will be taken • All outstanding training ie. HSEland Amric training and Human Rights Modules has been completed by staff. Completed 02-12-2022	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: To ensure compliance with Regulation 34 the following actions have been or will be taken • The Policy for the Management of Feedback (Complaints, Compliments & Comments) was discussed with Consumers Services and a response was provided to the Disability Manager on the 16/11/2022. The complaints management pathway explains the appropriate pathway for a complaint that is not upheld.	

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: To ensure compliance with Regulation 8 the following actions have been or will be taken: • Donegal Disability Service is currently developing a policy on the provision of safe Wifi usage in conjunction with the Digital Health Lead, Health and Social Care Professionals and in consultation with other care group services. Completion date: 31/12/2022	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	02/12/2022
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	16/11/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022