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:	Cloghan
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	27 September 2022 and 28 September 2022
Centre ID:	OSV-0008154
Fieldwork ID:	MON-0036786

About the designated centre

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

The centre is located within a small campus setting which contains three other designated centres operated by the provider. Cloghan provides full-time residential care and support to 3 residents. The designated centre comprises of a four bedded bungalow. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. Residents are supported by a staff team of both nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 September 2022	14:00hrs to 18:45hrs	Úna McDermott	Lead
Wednesday 28 September 2022	09:30hrs to 14:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

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

At the time of the inspection the provider had implemented a number of actions relating to governance and management (regulation 23), positive behaviour support (regulation 7) and protection (regulation 8). It was found on this inspection that further improvements were required to strengthen governance arrangements, the arrangements in place to ensure that residents were protected from abuse, and the systems used to record restrictive practices. These will be discussed in the other sections of the report.

There were three residents living in Cloghan at the time of inspection. The inspector was informed that an application to vary conditions of registration was intended. This would change the primary function of one of the rooms to provide an office space.

The inspector met briefly with all residents over the course of the inspection. However, the person in charge explained that one resident preferred a quiet and calm environment with familiar people. For this reason, interactions with residents were brief and kept to a minimum in order to accommodate this residents support needs.

On arrival, there was one resident at Cloghan. They were observed moving around the centre, turning on and off light switches and vocalising loudly on occasion. The remaining residents were out with staff and returned later. One resident met briefly with the inspector and they used words and signs to explain what they did that day. It was clear that the person in charge understood the resident's communication style and the interaction was observed to be supportive and respectful. Later that evening, two residents went to a hotel in the locality to socialise. They were supported by two staff members and were reported to enjoy this activity.

The person in charge told the inspector that one resident attended a day service on a regular basis. The second resident attended a day service at times and only if they choose to do so. The third resident was reported to prefer to stay in their home environment and would request to leave the centre from time to time. This was reflected in their positive behaviour support plan which will be expanded on later in this report. On the second day of inspection, this resident requested to go to the shop to purchase a record. The inspector observed that the resident found the transition to the transport provided was difficult and they appeared anxious. However, the support provided by the staff member on duty was gentle and encouraging and the trip was successful. The resident bought a record and a record player and they played music in their room that afternoon. This showed that familiar and consistent staff were required in order to support this resident's quality of life.

Longer trips were arranged for residents from time to time for example; a trip to a folk park in a neighbouring county took place over the summer months. On another occasion, a resident requested a trip home. This was arranged and the resident travelled by ferry which added to their enjoyment of their trip. Future plans were in place for the resident to meet with their family so that they could enjoy lunch together.

During this inspection improvements were found in the premises provided since the last inspection as a result of which, there was a non-compliance in relation to regulation 27; infection prevention and control. The centre appeared cleaner than previously found. The radiators had the rust removed and were painted. The person in charge told the inspector that the walls were not painted yet and that this was due to be completed in the near future. Most of the flooring repairs were complete. However, the gaps in the sitting room floor remained and this work was pending. The kitchen was observed to be neat and tidy and there was a plan in place to replace the microwave. The residents at Cloghan had their breakfast at their home, but lunch and dinner was delivered from a campus based kitchen. A review of the food stocks available found that a selection of options for a hot or cold breakfast were provided along with food for light meals or snacks if required. Each resident had their own bedroom and the inspector met with one resident at the entrance to their room. It appeared comfortable and personally decorated with a television displayed on the wall.

From observations at the centre, discussions with staff and a review of the documentation, it was evident that there were issues regarding compatibility of residents at this centre. This impacted on residents' feelings of safety and their quiet enjoyment of their home. Furthermore, difficulties in relation to the provision of an experienced and consistent staff team at Cloghan further impacted on the lived experience of the residents living at this designated centre and this required review.

Overall, the inspector found improvements in the systems and processes in place since the last inspection and work was ongoing. However, further advances in the governance, management and oversight of the service, along with a review of the systems used to submit notifications would enhance the quality of the service provided.

The following sections of the report outline the governance and management and how this impacts on the quality and safety of care provided to residents.

Capacity and capability

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

With regard to regulatory compliance, improvements were noted since the inspections in February 2022 and July 2022. However, ongoing improvements were required in relation to governance and management, safeguarding, staffing, notifications of incidents, documentation in relation to complaints, positive behaviour support and the premises provided.

As part of this inspection the governance and management arrangements in this centre were reviewed. The person in charge returned to post after a period of leave, in June 2022. At the time of inspection, they had responsibility for a second designated centre and said that they had the capacity to complete this role. An inspection based on Regulation 27 took place in July 2022. At this time, the inspector found that there was no clinical nurse manger 1 (CNM1) in post to support the governance arrangements in place. The arrangement for the provision of a CNM1 was reviewed during this inspection and it was found that there was no change since the previous inspection and post remained vacant. This was contrary to the statement of purpose provided and to the commitments made by the provider in their management improvement plan.

The statement of purpose was reviewed and updated in July 2022. Improvements in the oversight of this document were evident, however, as outlined above the staffing complement in relation to the CNM1 post was incorrect. In addition, an application to vary was pending and a plan was in place to submit this in the near future.

The staff team in Cloghan consisted of both nurses and healthcare assistants. The staff roster was reviewed and it was found to be an accurate reflection of the staff on duty on the day of inspection. The roster was updated on a daily basis and adequate numbers of staff were provided. This showed improvement since the

previous inspection. However, three staff members were on leave and there were ongoing difficulties in staff replacement. For example, over a ten day period, alternative cover arrangements were required nine times. This meant that either the person in charge, or staff from other designated centres were required to relocate to work in Cloghan. In addition to this, agency staff were required on twenty two occasions. The person in charge told the inspector that every effort was made to secure consistent and familiar agency staff members, the inspector found that six new staff were inducted to the service since July 1st this year. These resourcing matters impacted on the quality of the service provided in a centre where consistency of staff was acknowledged as essential.

Staff had access to training as part of a professional development programme. This included both mandatory and refresher training. The policy on staff training and development was up-to-date but required signing by all staff members. The person in charge had a training matrix and a sample of the training provided was reviewed. Modules included safeguarding and protection, positive behaviour support, fire safety and infection prevention and control. All modules in the sample selected were up to date and this showed improvement in the training systems in place. Staff had access to supervision meetings with the person in charge. These meetings commenced in July 2022 and two supervision meetings had taken place. One required signing but the person in charge had a plan in place to follow up on this. There was a plan in place for the remaining staff to have access to this support.

There were two complaints open in this designated centre at the time of inspection. One of these was in progress at a service level and the procedure used was reviewed. The inspector found that it was prompt, comprehensive and in line with the requirements of the providers complaints policy. It included a complaints record which recorded the nature of the complaint, the actions taken and the follow up required. This was completed in full. In addition, the inspector observed a picture of the complaints officer which was displayed on the notice board. An easy-to-read complaints and concerns policy was found on file, however it was incomplete and required review. For example, it did not include a photograph and contact details for the complaints officer, and the information on the appeals procedure was limited. Furthermore, it was not displayed in a prominent position for residents ease of access.

From a governance and management perspective, the inspector found that although there was a management structure in place with lines of authority identified, it was not in line with the centre's statement of purpose or commitments made by the provider in relation to strengthening the governance arrangements in Cloghan. This was due to the fact that the CNM1 role remained vacant. In addition, although every effort was made to provide sufficient staff resources, the lack of consistency impacted on the effectiveness of the care and support provided. A documentary review of the residents' files showed that consistent and familiar staff were required on an ongoing basis. This was documented in the residents' safeguarding plans, their behavioural support plans and in their nursing care plans.

The annual review of the quality and safety of care was completed in July 2022 and the six monthly provider-led audit was up to date. Actions identified were

documented on the centre's quality improvement plan. Governance meetings had commenced in July 2022 and two had taken place to date. However, a review of the minutes showed that only two of eleven staff attended each meeting. This meant that the actions identified through the annual review and the six monthly audit could not be effectively communicated to staff and the progress could not be effectively monitored.

The service introduced a new audit tool in August 2022. This included a range of quarterly, bi-monthly and monthly audits. The introduction of this audit tool was in progress and in relation to the safeguarding audit tool used, the need for further training and support was identified by the person in charge. Furthermore, the documentary review showed that the systems in place to ensure that policies, procedures, guidelines and protocols were signed by all staff required review. For example, the provider's policy on training and development which was in place since 2019 was signed by four out of eleven staff and the policy on the use of restrictive practices and restraint was signed by three out of eleven staff. The meant that the auditing measures in place in this regard required review.

The inspector reviewed the national incident management system used by the provider to ensure that all accident and incidents occurring were captured correctly and that an opportunity for learning was provided. The inspector found that not all events were notified to the Chief Inspector in line with the requirements of the regulation. For example, the restrictive strategies on residents' files were not notified as required.

In general, the inspector found improvements in the systems and processes in use in this centre. However, the issues in relation to resident compatibility and staffing resources continued to impact on the residents and on the quality and safety of the care provided. Further improvements were required with regard to the statement of purpose, the notification of incidents and the complaints procedure used to ensure full compliance with the regulations.

The next section of this report further describes the care and support provided and if it was of good quality and ensured that people were safe.

Regulation 15: Staffing

The person in charge had a roster in place and it was found to be an accurate reflection of the staff on duty on the day of inspection. The roster was updated on a daily basis and adequate numbers of staff were provided. However, three staff members were on leave and there were ongoing difficulties in staff replacement. For example, over a ten day period, alternative cover arrangements were required nine times. This meant that either the person in charge, or staff from other designated centres were required to relocate to work in Cloghan. In addition to this, agency staff were required on twenty two occasions. The person in charge told the

inspector that every effort was made to secure consistent and familiar agency staff members, the inspector found that six new staff were inducted to the service since July 1st this year. These resourcing matters impacted on the quality of the service provided in a centre where consistency of staff was acknowledged as essential.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to training as part of a professional development programme. A training matrix was in place and a review of a sample showed that all modules were up to date. Staff were supported through a programme of supervision meetings which had commenced and were in progress

Judgment: Compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme in January 2022, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO1. All actions were reviewed with the person in charge on inspection. In relation to meetings held, the inspector found that three actions had commenced and were ongoing. These included the centre level governance meetings, the quarterly safeguarding review meeting and the individual person in charge meetings which were held with the director of nursing and reported to be very supportive. The person in charge explained that they were not always able to attend four other meetings due to capacity and staff replacement issues. These included the county level person in charge meetings, the human rights committee meetings, the policy, procedure and protocol meetings and the governance for quality and safety meetings. However, they said that a colleague would attend, that minutes were circulated and a sample of these minutes were reviewed by the inspector. The additional three meetings were held at network level. The person in charge said that these had commenced, that feedback was requested from time to time and that updates were circulated. One final action related to an audit review and the inspector found that this had commenced and was ongoing.

At local level, the inspector found that improvements were required with the governance systems and processes in place in Cloghan to ensure that the service provided was a good quality and safe service and the following required attention;

- the management structure in place did not comply with the centre's statement of purpose or the commitments made by the provider in relation to strengthening the governance arrangements in Cloghan. This was due to the fact that the CNM1 role remained vacant
- the management systems in place were not effective in ensuring that a consistent staff team was provided in line with the assessed needs of the residents
- this impacted on the effectiveness of the care and support provided and the risk of behavioural escalations in the centre
- the systems place to ensure that the full staff team attended governance meetings on a regular basis were not effective
- the checks used to ensure that the providers documents were reviewed and signed by all staff to indicate their understanding were not effective

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose in place which was reviewed recently. However, improvements in the oversight of this document were required as follows:

- the staffing complement documented required review as the CNM1 role was not in place

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge did not ensure that all notifications were submitted to the Chief Inspector in line with the requirements of the regulation such as the use of restrictive practices.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had ensured that a complaints policy and procedure was in place, however the following required review;

- that the easy-to-read complaints and concerns policy was completed in full

- that the appeals procedure provided for was sufficient in detail
- that the policy was displayed in a prominent position for residents ease of access.

Judgment: Substantially compliant

Quality and safety

The inspector found improvements in the quality of the care and support provided to residents due to ongoing updating and review of the systems and processes in place by the person in charge. Improvements were also noted in the condition of the premises and the repairs completed to date were noted. This was a work in progress and will be expanded on later in this section. However, further review was required to ensure that residents were compatible, were safeguarded from abuse and that they felt safe in their home. In additional, the review of the restrictive practices used was required to ensure full compliance with the regulation.

All residents had a comprehensive assessment of their health, personal and social care needs completed this month. The inspector found that these assessment were comprehensive and included consultation with allied health professionals. For example, the additional support of a speech and language therapist was in place as per the recommendation of the compliance plan submitted by the provider. Furthermore, access to a positive behaviour support specialist and a psychologist was provided and their recommendations documented on residents files. There was an agreement in place to ensure that one resident would have a review of his assessment in the near future due to an escalation in his support needs.

All residents in this designated centre required support with positive behaviour and the inspector found that they had positive behaviour support plans in place. These plans were supported by crisis management plans, nursing intervention plans and restrictive practice strategies. All staff viewed as part of the sample selected, had training on positive behaviour support and support from a psychologist and positive behaviour support specialist was provided.

A review of the files and a discussion with the person in charge showed that there was an escalation of behavioural incidents in Cloghan recently. Throughout this file review, the inspector found reference to the need for consistent, skilled, experienced and familiar staff in order to best support residents' behavioural needs. This was discussed with the person in charge and the director of nursing who acknowledged the difficulties in staff replacement, the impact this had on residents and the escalations in their behaviours of concern. The inspector also spoke with a staff nurse who was providing replacement cover in Cloghan and who was familiar with the residents living there. They said that the most important requirement was a calm and a familiar environment as this reduced the risk of behaviour outbursts that

could impact on other residents.

The person in charge had a restrictive practice log in place. Environmental and chemical risks were recorded. However, the inspector found a restrictive strategy on a residents file in relation to support during phlebotomy procedures. A second restrictive strategy referred to 'holding' when a resident experienced anxiety and had escalation in their behaviour. Another resident was found to have restrictions on their access to cigarettes. A review of the incidents recorded showed that recently, when asked to wait for a cigarette, this resident experienced a significant behavioural event which impacted on the residents and staff at the designated centre. Although there was a rationale in place to explain the use of these restrictions they were not recorded on the restrictive practice log. Therefore, they were not assessed to check for alternatives or to ensure that they were the least restrictive strategy used for the shortest duration necessary. This required review.

The person in charge had measures in place to reduce the likelihood of safeguarding concerns occurring and the provider had ensured that an up-to-date safeguarding and protection policy was in place. The person in charge acted as the designated officer and there was an alternative plan in place if required. The inspector found that the designated officer was knowledgeable and experienced. If a safeguarding concern arose, the procedure was followed promptly and comprehensively. A safeguarding log was in use which ensured that outcomes of preliminary screening were documented, plans were implemented if required and learning gained. Monthly safeguarding and protection meetings were taking place in consultation with members of the CHO1 safeguarding and protection team. This was in line with an action committed to by the provider in the compliance plan submitted and referred to at the outset.

However, while improvements in the systems and processes in place were acknowledged, these were not always effective in ensuring residents felt safe and that they were protected from abuse. Discussions with the staff on duty and the director of nursing, along with a documentary review showed that there were significant concerns in relation to the compatibility of residents in this designated centre. Some residents were reported to become anxious due to the high level of noise and ongoing challenging behaviours occurring. Another resident was reported to prefer time alone, their own space and a quiet environment. One resident told staff that they did not enjoy living at Cloghan due to the noise. Furthermore, compatibility issues were raised by one staff member during their supervision meeting with the person in charge. In addition, they were documented on residents' safeguarding and protection plans and in the recent six monthly provider-led audit which read that 'noise and shouting contributes to safeguarding challenges in the home'. This meant that although there was significant progress in relation to the systems and processes in place, residents could not always be effectively safeguarded due to compatibility issues between residents in this designated centre.

Overall, there were good systems in place for risk management. There was a policy and procedure for risk management in place and a safety statement document which outlined emergency plans for the centre. A risk register was in place, however it required updating and the person in charge was in the process of completing this.

Risks at service level were completed and reviewed and residents had individual risk assessment on their files. These included the risks associated with inexperienced staff and the requirement for adequate supervision as a control measure. Also the risk of injury in relation to incompatibility and the requirement that a compatibility assessment is completed for all residents.

The person in charge told the inspector about improvements that had taken place in the premises since the last inspection. This included repairs to floor coverings, the painting of some areas and enhanced cleaning that had taken place. A system was established to ensure that maintenance matters were identified promptly and alerted to the maintenance department. Plans were in place to ensure that all matters identified were addressed in full. This included the repair of the floor in the sitting room and the painting of the communal areas which remained visually dirty. The person in charge continue to pursue this matter and said that works were planned.

Regulation 17: Premises

Improvements were noted in the premises provided and some works required were completed. Others were outstanding but the person in charge had a plan in place to ensure that they were completed in the near future.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems in place for risk management. There was a policy and procedure for risk management in place and a safety statement document which outlined emergency plans for the centre. A risk register was in place, however it required updating and the person in charge was in the process of completing this. Risks at service level were completed and reviewed and residents had individual risk assessment on their files.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

All residents had a comprehensive assessment of their health, personal and social care needs completed this month. The inspector found that these assessment were comprehensive and included consultation with allied health professionals. For

example, the additional support of a speech and language therapist was in place as per the recommendation of the compliance plan submitted by the provider.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements relating to positive behavioural support at the centre. One action related to the approval of MDT supports, three actions related to staff training and ensuring staff have knowledge about behaviour support plans and three actions related to the induction of new staff.

The inspector reviewed all actions with the person in charge and found that six actions were completed or ongoing. The one outstanding action found was in relation to the providers' commitment to the induction process for new staff, the details of which required review.

For the purpose of this inspection, the inspector found that the person in charge had ensured that residents that required support with positive behaviours had support plans in place. All staff viewed as part of the sample selected, had training on positive behaviour support and support from a psychologist and positive behaviour support specialist was provided. However, the following required review;

- the need for consistent, skilled, experience and familiar staff as documented in residents files and care plans
- the use of restrictive strategies in relation to 'holding' and access to cigarettes to ensure that they are acknowledged as restrictive and assessed and reviewed accordingly

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements relating to protection at the centre.

The inspector reviewed all actions and found that 11 actions were completed or ongoing. The two outstanding actions included the provision of a policy on provision of safe wifi usage which the person in charge reported was being progressed at a national level. The second related to the provision of training on 'speakeasy plus'

which had not commenced at the time of inspection.

On this inspection it was found that the arrangements for safeguarding required improvements. While the person in charge had measures in place to reduce the likelihood of safeguarding concerns occurring these were not always effective in ensuring residents felt safe and that they were protected from abuse. This was due to significant concerns in relation to the compatibility of residents in this designated centre.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Cloghan OSV-0008154

Inspection ID: MON-0036786

Date of inspection: 27/09/2022 and 28/09/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Person in Charge in conjunction with the Director of Nursing will complete a full review of staffing within the centre - Date for completion 14/11/22 • The Person in Charge will ensure that there are regular agency staff assigned to the centre to ensure consistency for all residents – Completion date 01/10/22 • The Director of Nursing in liaison with the person in charge will complete a support needs assessment for all residents within the centre – Date for completion: 31/12/22	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Clinical nurse manager 1 position has been accepted and the successful candidate will take up post once a start date has been agreed – Date for completion 15/12/22. • The Person in Charge will ensure that there are regular agency staff assigned to the centre to ensure consistency for all residents – Completion date: 01/10/22 • The Director of Nursing in liaison with the person in charge will complete a support needs assessment for all residents within the centre – Date for completion: 31/12/22 • The Person in Charge in conjunction with the Director of Nursing will carry out a review of staffing and ensure that a consistent staff team are available to provide a quality service for the residents living in the centre – Date for completion 14/11/22 • The Person in Charge has reviewed the schedule in place for governance meetings to ensure that the full staff team have the opportunity to attend all meetings. Completion date: 17/10/22 • The Person in Charge will complete a full audit of all policies and procedures and staff	

sign off of same – Date for completion 15/11/22 • The Person in charge will discuss with staff at the next governance meeting the requirement for sign off of all policies – Date for completion: 30/11/22

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • The Person in Charge has reviewed and updated the statement of purpose to ensure the staffing complement is accurate and reflective of the staffing within the centre – Completion date 31/10/22	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • The Person in Charge has retrospectively ensured that all notifications in relation to restrictive practices were submitted to the regulator. Completion date 27/10/22 • The Person in Charge will ensure that all notifications are submitted to the regulator within the required timeframes as per the regulations – Completion date 27/10/22	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The person in charge has updated the easy to read complaints and concerns policy to include the point of contact persons (formally complaints officer) photograph and contact information – Completion date 31/10/22 • The person in charge has ensured that the easy to read policy is displayed in prominent position that is accessible to all residents – Completion date 31/10/22 • The Person in charge will ensure that all relevant documentation is updated to reflect the change in processes in line with the new complaints and concerns policy. With specific reference to there no longer being an appeals process Consumer Services have been now requested to review same. Date for completion 30/11/22	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Person in Charge will continue to monitor and report all maintenance matters identified within the premises in a timely manner to ensure all works are completed routinely – Completion date 31/10/22
• The person in charge in liaison with maintenance manager will ensure that all outstanding works i.e. painting and external works are carried out – Date for completion 31/12/22

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The Person in Charge in conjunction with the Director of Nursing will complete a full review of staffing within the centre - Date for completion 14/11/22
• The Person in Charge will ensure that there are regular agency staff assigned to the centre to ensure consistency for all residents – Completion date 01/10/22
• The Person in Charge has completed a review of all restrictive practices within the centre including the holding and access of cigarettes and support during phlebotomy - Completion date 27/10/2022
• The person in charge has ensured that all restrictive practices including the holding and access of cigarettes and support during phlebotomy is acknowledged as a restrictive practice and has been notified to the regulator as per the regulations – Completion date 27/10/22
• The Person in Charge will ensure that MDT reviews of restrictive practices are completed within an agreed timeframe – Completion date 14/11/22

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The provider is currently developing a Safe Wifi Usage Policy for the Service. A request

for an extension for this specific action has been sought by the Head of Service Disability Services on the overall Donegal Disability Services Compliance plan. – Date for completion 31/12/2022

• The Person in Charge, staff working in the centre, Director of Nursing and the wider Multi-Disciplinary Team attend regular compatibility meetings where the compatibility of residents within the centre is reviewed – Date for Completion 31/12/22

• The Person in charge continues to attend monthly safeguarding meetings where any issues relating to safeguarding and compatibility are reviewed – Completion date 25/10/22

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/12/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is	Not Compliant	Orange	31/12/2022

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/10/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	27/10/2022
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a	Substantially Compliant	Yellow	30/11/2022

	prominent position in the designated centre.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	14/11/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	14/11/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022