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:	Dunshenny House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	30 September 2024
Centre ID:	OSV-0007987
Fieldwork ID:	MON-0044550

About the designated centre

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

Dunshenny House provides full-time residential care to adults with moderate to severe intellectual disability. The service comprises one building which is located close to a busy town. Residents are supported with co-existing conditions such as mental health illness and/or behaviours of concern, special communication needs, physical illness and conditions such as epilepsy and diabetes. Dunshenny House is accessible for people who are wheelchair users. Residents are supported by a qualified team of nurses and healthcare assistants who provide 24 hour care. Active night duty arrangements are in place.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 30 September 2024	10:00hrs to 14:00hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor and review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013).

Concerns relating to the quality of care and support and the safety of this service were found previously and the provider was subject to an escalation in regulatory activity and enhanced monitoring. The most recent inspection took place in May 2024. The inspector found that the provider had taken significant action since then. The leadership arrangements in the centre were strengthened and the governance and management systems improved. This had a positive impact on the stability of the service and the lived experience of the residents residing at Dunshenny House. Further work relating to the oversight of staff training and centre level risk documentation was required which would further improve the quality and safety of the service.

Dunshenny House provides a home for three residents and is located in a rural area on the outskirts of a busy town. Two residents lived in the main house and one resident lived in an annex to the main building. Each resident had their own bedroom and bathroom facilities. In the main house, there was a combined kitchen and dining room which was well equipped to meet with the residents needs. The sitting room was bright and cheerfully decorated. The annex provided living accommodation for one resident with high support needs and who experienced significant behaviours of concern. The design of the building meant that residents lived close to each other, while having their own space in line with their particular support needs.

This inspection took place over one day. On arrival, the inspector sat with two residents and their staff in the living area. On approach, a staff member was observed speaking kindly to a resident about an appointment that they were due to attend that morning. This interaction was gentle and supportive. The staff member spoke about the importance of familiar staff when attending appointments with the resident as if they felt reassured, then things would go smoothly. Another resident was moving from room to room. Staff told the inspector that they did not sleep well the previous night. They said that this was not unusual for the resident. Although they did not communicate verbally, the resident was observed making different sounds during the time spent in the sitting room. It was clear that staff understood what this meant, for example, if they were tired and how best to support them. Both residents went on a short break recently, where they stayed in a hotel and visited tourist attractions in the area. Staff said that this trip went very well and that the residents enjoyed it very much.

Later, the inspector spent time with the resident living in the annex to the building. Staff supporting this resident requested permission for the visit and were respectful

in the introductions. The resident appeared content that day and the staff present said that they were more settled and there was a decrease in the frequency of incidents. The resident was relaxing in a comfortable chair with a weighted blanket which they seemed to enjoy. The inspector noted that they spoke regularly during this inspection which was different to previous. They expressed their dislike of a clinical procedure and when explored further, the inspector found that their right to decline this procedure was respected. In addition, they spoke about their enjoyment of making decorations for festive celebrations and they moved their hands to show that they liked decorations that opened out like a concertina. The resident's relationship with staff members was observed as pivotal. The staff were skilled, knowledgeable and patient. This were very familiar with the resident's communication style which meant that their voice could be heard. It was clear that this was important to staff as a cheerful hand-drawn visual schedule was on the notice board. It was personalised and showed the resident on a bus, going on a home visit and visiting a coffee shop. Staff said that this was useful as it provided reassurance to the resident about their plans for the day.

The inspector met with the person in charge, the assistant director of nursing and three members of the core staff team during the day. All were consistently employed. They spoke about improvements which were at early stages of progress. In particular, they told the inspector that the recruitment of a substantive person in charge had a positive impact on the centre and on the staff team. However, they expressed some caution about the retention of the management presence in the centre due to the amount of changes in the past. In addition, they said that the ability to sustain the improvements was important to them.

Overall, the inspector found although at an early stage, the provider had taken action to improve the governance and oversight of the service which impacted positively on the quality and safety of the service. This was in line with the commitments made by the provider in the compliance plan submitted to the Authority following the May inspection. While there were improvements to the stability of the staff team and the resident's lives, further work was required to address some gaps in training provision and oversight of risk registers. Both of these will be reported on under regulation 23 below.

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

Capacity and capability

The registered provider had recruited a new person in charge to the centre, who commenced employment three weeks prior to this inspection. This meant that the governance and management arrangements were strengthened. A process of review and updating of the documentation systems had commenced, however, this was at

an early stage and further review was required in order to reach compliance.

A review of staffing arrangements found improvement. The planned and actual roster was well maintained and provided an accurate account of the staff on duty on the day of inspection. Staff were employed consistently and nursing care was provided in line with the statement of purpose.

Staff had access to mandatory and refresher training as part of a programme of professional development. Records were maintained on a training matrix which captured both core and agency staff training. While some training required updating, a plan was in place to progress this.

The centre was adequately resourced. The premises was well presented, equipment was available in line with residents needs and transport was provided. The provider had an audit schedule to guide staff and a quality improvement plan to capture gaps identified through the audit process.

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 14: Persons in charge

Following the May 2024 inspection, the provider made a commitment to ensure that the cover arrangement for the absent person in charge was reviewed and replaced with a substantive leadership and management arrangement. This was achieved.

The person in charge commenced on 9 September 2024, they were employed full-time and had the appropriate qualifications, skills and experience to meet with the requirements of this regulation.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that there were improvements in staffing arrangements since the last inspection.

- Sufficient staff were employed. They had the right skills, qualifications and experience to meet with the assessed needs of the residents.
- This was a nurse-led service and nursing support was provided in line with the statement of purpose of the centre.
- The staff team were consistent. The person in charge told the inspector that there was one vacant nursing post and one vacant healthcare assistant post. However, a stable and consistent cover arrangement was in place.

- A review of the planned and actual roster for a three month period (1 July to 30 September 2024) found improvements. The name and the availability of the person in charge was clearly documented. Changes to the roster were few and if required, the rationale was clearly documented and recorded.

Judgment: Compliant

Regulation 16: Training and staff development

The provider found that the provider was working towards compliance in this regulation and had taken significant steps since the May inspection. For example,

- Staff had access to mandatory and refresher training modules as part of a professional development programme.
- Where specific training was required in order to enhance the service, this was provided. Members of the staff team had completed training in care planning the previous week.
- The provider had reviewed and improved their training matrix and it included agency staff. This meant that all training records were documented and available for review in the centre.
- A review of the matrix was completed on the date of inspection. The person in charge told the inspector that 5 staff had some training modules to complete and a plan was in place to secure training places and release the staff to attend same. This will be reported on under the governance and management section (regulation 23).

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that this designated centre was well resourced. The service provided was person-centred and in line with the statement of purpose and improvements in governance were found. For example;

- The registered provider recruited a person in charge who was employed full-time and available to support the needs of the service.
- Staffing levels in the centre were reviewed and improved. Consistency of care and support was provided.
- Residents who required positive behaviour support had access to specialists and support plans were in place.
- Safeguarding arrangements in the centre were improved and staff spoken with were aware of what to do if a concern arose.
- The provider had an audit system in place to support the oversight of the

service. The annual review was up to date and the provider-led six monthly audit was completed on 19 August 2024.
- Actions identified were captured on a quality improvement plan which was last reviewed on 25 September 2024.

However, as the person in charge commenced employment three weeks prior to the inspection date, progress in some areas was at an early stage. The following required further work,

- Although risk management plans were in place, the risk register was last updated on 14 March 2024. 13 risks were documented, 12 of which had a low risk rating. For example, the risk of violence and aggression was assessed as a low risk, while the risk of contaminated sharps was assessed as a medium risk. This did not correspond with the findings of the inspection.
- In addition, although there were significant improvement in the oversight of staff training, further work was required to ensure that all training modules for all staff were up to date.

Judgment: Substantially compliant

Quality and safety

Residents living at Dunshenny House had were provided with good quality care and support. Improvements to staffing arrangements meant that person-centred care was provided and efforts were made to ensure that the voice of the resident was heard and respected.

Residents who required positive behaviour support has access to a behaviour support specialist. An integrated approach was used which involved members of the multi-disciplinary team and plans used were subject to regular review. Restrictive practices were used in this centre, however, protocols were in place and the least restrictive option was used for the shortest duration.

The provider had arrangements in place to ensure that residents were protected from abuse. The layout of the centre ensured that residents lived in appropriate living spaces and this reduced the possible impact on behaviours of concern on the wellbeing of others. However, the oversight of safeguarding and protection training and documentation systems required review to ensure that clear guidance was provided for staff.

The inspector found that the provider had taken action to address the safeguarding concerns found previously. There were no open safeguarding concerns at the time of inspection. All staff had up to date training and those spoken with were aware of what to do should a safeguarding concern arise.

Most risk management systems were reviewed by the provider and residents

individual risk assessments were updated. The oversight of the centre's risk register and corresponding risk ratings required further work to ensure accuracy. This is actioned under regulation 23 above.

In summary, the inspector found that the provider had taken significant action to improve the quality and safety of the service since the last inspection in line with the compliance plan submitted to the Authority. Some actions relating to staff training and risk management were yet to be completed which are reported under the governance and management section of this report. While the improvement were acknowledged as positive, ongoing work was required on behalf of the registered provider and the person in charge to sustain the stability of the service and to progress the quality improvement measures which were at an early stage of development at the time of inspection.

Regulation 26: Risk management procedures

The provider had systems and process for risk management at this centre. This included an up-to-date policy and procedure for risk management and a process for risk escalation.

- Residents had individual risk assessments relating to all risks identified which were linked to behaviours support strategies and care plans if necessary. Corresponding controls measures were in place to mitigate against the risk. These were clearly documented. Risk ratings were applied in line with the provider's policy.
- The inspector identified some gaps in the completion of documentation, such as the updating of the risk register. The new person in charge had a plan to correct this and this matter is reported on under governance and management (regulation 23).

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required positive behaviour support this was provided.

- The inspector was aware that a resident with complex and high risk behaviours of concern had experienced a difficult few months. However, staff spoken with told the inspector that the number of risk behaviours had reduced, that they appeared to be feeling better and that their speech was coming back.
- This resident had a comprehensive behaviour support plan which was reviewed four times since the May inspection with the most recent review on 5 September 2024. It included all behaviours experienced by the resident.

- Proactive support strategies were provided and where recommendations were made, the inspector found that they were actioned promptly. For example, a communication dictionary was designed to assist staff understand the resident's communication style. In addition, a referral to speech and language therapy was completed as recommended. Furthermore, the plan recommended the provision of a high staff ratio of consistent, experienced and trained staff. This was provided and staff spoken with told the inspector that this had a positive impact on the resident's lived experience.
- Restrictive practices were used in this centre. However, protocols were in place which meant that all alternative measures were considered first. For example, a resident required a hand holding approach during some clinical procedures. The inspector observed a staff member discussing the doctor's visit with the resident before the appointment and completing the relevant recording protocols afterwards. This meant that the protocols were adhered to.

Judgment: Compliant

Regulation 8: Protection

The inspector found that the provider had taken action to address the safeguarding concerns found previously. For example;

- The person in charge ensured that all staff had appropriate training in relation to safeguarding residents. Safeguarding audits were completed with staff and those spoken with had a good understanding of how to prevent, detect and respond to allegations of abuse.
- Safeguarding documentation was readily available for review in the centre. Errors in documentation as found previously were corrected.
- Safeguarding measures such as intimate care plans were used in this centre. They were completed in full and reviewed regularly. In addition, the recommendations were linked into nursing care plans which ensured consistency of care.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dunshenny House OSV-0007987

Inspection ID: MON-0044550

Date of inspection: 30/09/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

To ensure compliance with Regulation 23: Governance and management the following actions have been/ will be undertaken.

• The PIC has reviewed the risk register for the centre to ensure all risk ratings are accurate and reflective of the centre. Completion date: 31-10-2024

• The training matrix for the centre is monitored and reviewed by the PIC on a monthly basis.

• The PIC has scheduled manual handling training for 4 staff on the 12th December 2024. Completion date 31-12-2024

• The PIC has scheduled food hygiene training for 1 staff on the 28th November 2024. Completion date 31-12-2024

• The PIC has developed a schedule for the completion of performance review meetings for 5 staff in the centre. Completion date: 31-12-2024.

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2024