Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation and Monitoring of Social Care Services

Overview report of governance and safeguarding in HSE designated centres for people with disabilities in Donegal in January 2022

Safer Better Care

Contents

Introduction

The Chief Inspector of Social Services in the Health Information and Quality Authority (HIQA) is the independent regulator of designated centres, including designated centres for people with disabilities. Regulation assures the public that people living in a designated centre are receiving a service that meets regulations and strives to reach national standards. Regulation promotes and protects the health, wellbeing and quality of life of people in residential care, and plays an important role in driving continual improvement so that residents have better, safer lives.

The Health Service Executive (HSE) is a registered provider of designated centres for adults and children with disabilities. As a registered provider, the HSE must ensure that there are effective governance arrangements that provide safe quality services to people living in those services.

On foot of recent serious concerns regarding safeguarding in one HSE centre in the Donegal area and ongoing concerns regarding the sustainability of effective governance arrangements in that area, the Chief Inspector escalated concerns regarding the fitness of the HSE to be the registered provider of centres in Co. Donegal to the HSE's Interim National Director of Community Operations.

In addition, as the independent regulator, the Chief Inspector initiated a regulatory programme to assess the HSE governance and management in Co. Donegal, particularly relating to safeguarding of residents. This report sets out the findings of that regulatory review.

Overview of regulatory activity

Since the commencement of regulation of designated centres for people with disabilities in 2013, the Chief Inspector has raised concerns about the HSE's ability to sustain effective governance and oversight of designated centres for people with disabilities in Community Healthcare Organisation Area 1 (CHO1). This has been evidenced by repeated escalated regulatory action in the area over a number of years.

In 2021, the Chief Inspector became aware of a recent serious safeguarding incident which raised further concerns over the HSE's oversight, governance and fitness to operate these centres in Co. Donegal.

Of particular concern to the Chief Inspector is that, while in most cases the HSE in CHO1 has initiated actions to address the specific areas of concern identified during inspections, the HSE's own surveillance and oversight of centres has repeatedly failed to identify the issues for itself.

There have also been instances where the HSE has taken action to improve the safety and quality of life for residents but then failed to ensure that those improvements were sustained. There has been an ongoing requirement for escalated action in relation to centres in the Co. Donegal area.

In contrast, there have been noted improvements in the management of services and in the quality of care and support for residents in the Co. Sligo area (also in CHO1), which demonstrates that the HSE has the capacity to effect change.

To date, and since 2013, escalated action taken by the Chief Inspector in relation to CHO1 has included:

- seven cautionary meetings,
- 16 warning letters,
- 32 instances where the provider was required to undertake its own investigation into issues of concern
- and four notices of proposal to cancel the registration of a centre, where the provider failed to take action to improve the quality of service for residents.

For example, in March 2021, the Chief Inspector issued warning letters to the provider in relation to three centres on the Ard Greine Court campus in Stranorlar, Co. Donegal. Previous improvements made in these centres had not been sustained by the provider and inspectors found non-compliances with a range of regulations including safeguarding issues relating to failure to protect residents from the impact that behavioural issues were having on their safety and quality of life.

Overall, inspectors found that the quality of care for residents in those centres had deteriorated. The provider had failed to monitor the effectiveness of its own programme of improvement actions in the centres. The provider was warned that failure to effectively implement its own improvement plan would result in the cancellation of the registration of those centres.

Further to that, in October 2021 the provider submitted a statutory notification to the Chief Inspector in relation to a very serious safeguarding incident in a HSE centre in Co. Donegal. The incident had occurred in July 2021 and the provider had failed to notify the Chief Inspector within three days as required by the regulations. An unannounced risk inspection[1] was undertaken in November 2021, where the inspector found that the provider failed to implement its own safeguarding policy and procedures in relation to the incident — the *Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures* — and there had been a three-month delay in engaging with appropriate multidisciplinary professionals to develop a

[1]This inspection report has not been published to safeguard the privacy of residents.

safeguarding plan to ensure the safety of the resident involved and others.

In addition, the inspector found evidence that similar incidents had occurred in 2016 and 2017. While there was evidence that the provider had notified An Garda Síochána, it had failed to notify these incidents to the Chief Inspector as required under the regulations.

While some actions had been taken at a local level in response to these incidents, there was no evidence of ongoing monitoring, implementation of supports to assist the resident to learn from the situation or implementation of control measures to minimise or prevent recurrence. There was also a failure to follow up on recommended specialist referrals for the resident. This failure to implement and follow up on such actions has potentially resulted in this resident facing life-changing consequences.

Given the level of previous escalated action in CHO1, and the failure of the HSE to sustain improvements and effective governance, the Chief Inspector took a number of actions:

1. On 10 December 2021, the Chief Inspector escalated concern nationally to the HSE as the legal entity responsible for the designated centres, requiring the HSE's national office to take action in response to the specific safeguarding issue identified on the November 2021 inspection.
2. The Chief Inspector required the HSE's national office to undertake a review of safeguarding in all HSE operated centres in Co. Donegal to assure itself and to assure the Chief Inspector that there were no other safeguarding concerns that had not been appropriately responded to.
3. The Chief Inspector required the HSE's national office to undertake a full review of governance and oversight of designated centres in CHO1 at local and at national level.
4. The Chief Inspector developed and undertook a programme of targeted inspections focusing on governance and safeguarding.

On 16 December 2021, the HSE's Interim National Director of Community Operations responded to the Chief Inspector and set out details of the actions being taken in relation to the specific issue identified on the November 2021 inspection. In addition, the response included details of the HSE's plan to review the overall governance and oversight of disability services in CHO1. This included input from the HSE's National Safeguarding Office and from HSE management, external to the management team in CHO1.

On 18 January 2022, the Chief Inspector met with the HSE's Chief Operating Officer, Interim National Director of Community Operations and other senior national HSE managers to discuss the HSE response and to put arrangements in place for communication between the HSE and the Chief Inspector during implementation of

the HSE's actions.

Targeted regulatory programme

Given the previous failures of the HSE to sustain improvement in governance in Co. Donegal's disability services and previous safeguarding concerns in HSE centres in the county, the Chief Inspector developed and initiated a focused inspection programme which focused on the effectiveness of accountability arrangements to ensure a good quality of support and care for residents in HSE-operated centres in Co. Donegal.

The purpose of this regulatory programme was to assess the provider's compliance with the specific regulations[2] identified for this targeted programme and to identify whether there were any further current safeguarding issues that were not being appropriately responded to by the provider.

In total, as of 28 January 2022, the HSE was operating 30 designated residential centres in Co Donegal. In January 2022, 18 of these centres were inspected. In effect, between September 2021 and 21 January 2022, all HSE designated centres in Co. Donegal had been inspected with the exception of three, two of which had only recently begun operating and one which was managing an infection control issue at the time of the January inspection programme.

All inspections in the January 2022 targeted programme were unannounced and carried out over a two-week period from 11 January to 21 January 2022. During this two-week regulatory programme, inspectors met with 69 residents and 80 staff members, including all persons in charge. In addition, inspectors spoke with both middle and senior management in CHO1. The programme was completed on 28 January 2022.

Separately, the Chief Inspector required the HSE to undertake a review to assure both themselves and the Chief Inspector that there were no previous safeguarding issues in centres in Co. Donegal that had not been appropriately responded to.

Three regulations were identified to assess the overall effectiveness of the HSE supervision, governance, oversight and safeguarding measures in Co Donegal designated centres. These regulations were:

- Regulation 23: Governance and management
- Regulation 8: Protection
- Regulation 7: Positive behavioural support.

[2] Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

During inspections, inspectors also considered the quality of life for residents in the centres.

Summary of findings

Overall, inspectors made a number of positive findings throughout the January 2022 inspections:

- While safeguarding concerns can arise in any centre, inspectors found that current safeguarding concerns were being responded to appropriately by the HSE. However, safeguarding arrangements needed to be strengthened to ensure that any issues that do arise are identified, escalated and responded to quickly.
- Staff were seen to be respectful of residents and to support them in a kind and caring manner.
- The provider had continued to improve the physical environment of centres. With the notable exception of one centre discussed further in this report below, inspectors found that residents had pleasant, homely environments that were personalised and comfortable.
- Persons in charge were suitably experienced, qualified and knowledgeable about their centres, and were working towards ensuring a good quality and safe service for residents.
- Persons in charge told inspectors they had good support from their managers who were available to them should the need arise.

However, inspectors found that the HSE needed to improve and ensure the efficacy of its governance and oversight arrangements. Inspectors found that the supervision and governance of centres from middle management and senior management was poor. These findings included:

- Due to an absence of a clear and collective understanding of the threshold of reporting and an over-reliance on the ability and discretion of each person in charge to identify when things went wrong in centres, there was a risk that not all serious safeguarding risks would be identified and appropriately escalated.
- Significant time was spent by staff on auditing; however auditing, oversight and trending of incidents were generic, poor and ineffective in identifying risks specific to the centre.
- There were inadequate formal supports and supervision for persons in charge.
- There was ineffective communication of strategic and operational plans to all layers of management and stakeholders.

Should there be failure to address these poor governance and oversight arrangements, it remains conceivable that another safeguarding incident may

occur similar to that which was identified in November 2021. These findings are discussed in more detail below.

The HSE as a registered provider

Unlike in other areas of the country, the HSE is by far the largest provider of direct services to people with disabilities in CHO1, including in Co. Donegal. In total, the HSE directly operates 30 of the 37 designated centres for people with disabilities in Co. Donegal. The total number of residential places in designated centres for people with disabilities in Co. Donegal is 233, with 194 of those residential places being in centres directly operated by the HSE.

The Chief Officer is responsible for oversight of the CHO area and reports to the HSE's Interim National Director of Community Operations. Within CHO1, each designated centre has a person in charge who reports to either a Director of Nursing or to an Area Coordinator. These in turn report to a Disability Manager, who reports to the Head of Social Care for Disability. The Head of Social Care reports to the Chief Officer. The organisational structure of CHO1 is set out in Appendix 2.

In January 2022, there were 19 persons in charge across the 30 designated centres operated by the HSE in Co. Donegal — with 11 of these responsible for managing day-to-day operations in more than one centre. The persons in charge report to either a Director of Nursing or an Area Coordinator. One of the persons in charge manages two centres, each one under the responsibility of a different Director of Nursing/Area Coordinator which meant that the person in charge effectively had two line managers. The provider has recognised this as an issue and informed inspectors that changes were planned to ensure clearer management of this situation.

The following table sets out the centres directly operated by the HSE in CHO1.

Centre ID number	Centre name	No. registered residential places
OSV-0002495	Saimer View	5
OSV-0002503	Cill Aoibhinn	13
OSV-0002496	Inbhear na Mara	10
OSV-0008147	Eske House Community Group Home	2
OSV-0002531	Drumboe Respite House	5
OSV-0002518	Sliabh Glas	6
OSV-0002517	Ballymacool Respite House	5
OSV-0002519	Ballyduff Park	8
OSV-0002523	Ballytrim House	8
OSV-0003331	Dungloe Services	8
OSV-0002506	Dungloe Services 2	12
OSV-0002508	St. Martin's Community Group Home	4
OSV-0007235	St. Anne's – Naomh Aine's	4
OSV-0003338	Fernhill Respite House	3
OSV-0003339	Moville Community Group Home	4
OSV-0002502	James Connolly Memorial Residential Unit	19
OSV-0002501	Riverwalk Respite House	3
OSV-0007991	Teach Sona	4
OSV-0005250	Abbey Village Community Group Homes	15
OSV-0005490	Dreenan Ard Greine Court	6
OSV-0005488	Railway View	4
OSV-0008153	Finnside	4
OSV-0005489	Dunwiley	5
OSV-0008154	Cloghan	3
OSV-0008152	Riverside	6
OSV-0005487	Edencrest & Cloghan Flat	6
OSV-0005248	Ard Clochar Community Group Homes	14
OSV-0008151	Mol na Oige	1
OSV-0008146	Tus Nua	4
OSV-0007987	Dunshenny House	3

The centres highlighted in yellow are those based on the Ard Greine Court campus in Stranorlar, Co. Donegal.

Inspection findings

This section of the report sets out the aggregated findings of the inspections since September 2021 and includes the 18 inspections that were completed in January 2022.

Regulation 23: Governance and management

The inspections found shortcomings in the oversight of centres and poor supervision and support arrangements for persons in charge. These shortcomings increased the risks of recurrence of issues such as the one that was identified on inspection in November 2021.

Inspectors found that poor quality surveillance of centres by the HSE had resulted in issues of concern not being identified in a timely manner and responded to appropriately. The provider was heavily dependent on the ability and discretion of the person in charge and on inspection activity by HIQA to identify when things went wrong in centres.

On the January inspections, inspectors met with each of the persons in charge and reviewed how they were managing their centres. Overall, persons in charge were found to be competent, knowledgeable and experienced. Persons in charge confirmed that they had ready access to their managers by phone and that their managers visited the centres regularly. In addition, inspectors spoke with Directors of Nursing/Area Coordinators and they described how they did 'spot checks' on centres as part of their oversight. However, these were not formal arrangements, there was no record of what was reviewed and different managers gave different descriptions of how they undertook this activity.

Inspectors also found that supervision for persons in charge by their managers was informal and inconsistent. The Directors of Nursing/Area Coordinators relied heavily on the person in charge to recognise, identify and escalate any issues or concerns within the centre to them. Apart from an annual personal development plan meeting with their manager, there were no formal supervision meetings for persons in charge to review their performance or the quality of service, or where persons in charge had protected time with their manager to discuss their centres.

Persons in charge described regular group management meetings with their line managers as part of the accountability arrangements. These meetings involved all persons in charge and day service managers under the Director of Nursing/Area Coordinator's remit. By their nature, these meetings covered more general issues rather than providing oversight of the individual designated centres. Inspectors reviewed a sample of minutes from these meetings and found limited evidence of

shared learning or trending in relation to critical areas such as behavioural concerns and safeguarding. Discussions were focused on training updates, policy changes, auditing requirements and general day-to-day operations within the geographical remit.

Inspectors found that there was an extensive auditing programme within each centre, with weekly, monthly and quarterly audits being undertaken. However, the audits were generic and did not reflect the different residents' needs in different types of service. For example, the same audits were being conducted in centres for people with significant healthcare needs as those conducted in centres where residents had high levels of independence and much lower healthcare needs.

The audits tended to be quantitative, gathering figures and statistics, rather than considering the quality of the areas being audited. For example, the audits contained the number of safeguarding plans within a centre and whether they had been updated. The audits did not give consideration to the relevance and effectiveness of the safeguarding plans. In another example, the audit template asked whether actions were in place to support residents to develop knowledge, self-awareness, understanding and skills to enable self-care and protection. The audit noted that the centre was compliant with this requirement based on staff being provided with safeguarding training and staff having An Garda Síochana (police) vetting, neither of which related to enabling self-care and protection for residents.

A person nominated by the provider was conducting six-monthly reviews within all of the centres, as required by the regulations. Inspectors read a sample of the reviews in each centre and found that, in general, the content reflected what was described in the person in charge's local audits rather than a rigorous, qualitative review of the safety and quality of care that related to the centre or specific lines of enquiry. For example, in one centre restrictive practices had been implemented in January 2020 and were not consistently being recorded in the centre's own auditing tool. The provider's six-monthly review did not identify this as a gap. As a result of ineffective auditing at both levels, the use of these restrictive practices were not being adequately managed within the centre to ensure the least restrictive practice possible was in place for all residents. In addition, the provider was failing to ensure that the required notifications were being submitted to the Chief Inspector.

Persons in charge did develop quality improvement plans based on the audit findings and on inspection findings. Progress reports on improvement goals were being submitted to the Directors of Nursing/Area Coordinators by the persons in charge. Inspectors reviewed a sample of these in each centre and found that they did not always capture the issues within the centre that were most impactful on the safety and quality of life of residents. For example, in a centre where there had been a high

level of behaviour incidents, the audits and the quality improvement plans had failed to identify this as an issue. In another centre, a person in charge had been absent for more than 28 days and during this time no one completed the ongoing monitoring of the quality of support and care in the centre.

A common theme that emerged from the meetings with persons in charge, Directors of Nursing/Area Coordinators and senior CHO1 managers was that there were poor communication pathways between the different management levels in Co. Donegal. For example, inspectors noted that a person in charge had escalated significant premises-related risks in one centre to senior HSE management and informed the inspector that they did not receive a response to the risks. There was no documentary evidence from middle or senior management to acknowledge receipt or indicate any actions. However, when inspectors spoke with senior managers, they outlined a detailed plan to address the issues, which had not been communicated to the person in charge, staff or residents.

In another example, three persons in charge spoke of their concerns about the delay in sanctioning replacement staff in their centres and told inspectors that they had no update on the recruitment of these staff. When inspectors discussed this with senior managers, they identified the process for appointing staff and the progress on appointing those staff in the centres. In another centre, the provider's six-monthly review had been undertaken but the results of that review were not communicated to the person in charge until six months after the review, thereby not ensuring a timely response to any issues identified.

The communication of organisational strategic and operational plans to relevant managers also required improvement. Directors of Nursing/Area Coordinators told inspectors of their recruitment plans for social care workers as part of a transition to a social care model of service provision. The Directors of Nursing/Area Coordinators told inspectors that they were not yet aware of criteria for assigning social care workers to specific residential centres, and that their focus was on creating a panel of social care workers for appointment when sanctioned. However, senior managers in CHO1 described to inspectors a staff skills benchmarking process that had been completed in each designated centre, criteria for the appointment of new staff and plans for the allocation of new staff to each of the centres.

In summary, while there were arrangements in place to undertake audits and reviews of centres, review of these arrangements was required to ensure they were effective. In addition, the HSE needs to review the arrangements whereby the person in charge was relied on to recognise, identify and escalate issues of concern, should they arise in a centre, in the absence of clear guidance and oversight. As a provider, the HSE is required to have robust governance arrangements to

sustainably deliver safe, effective and reliable person-centred care in each designated centre. These arrangements should ensure that the HSE is confident that risks can be identified and responded to in a timely manner.

Regulation	Judgment
Regulation 23: Governance and management	Not compliant

Regulation 8: Protection

Safeguarding is, first and foremost, about proactively protecting people and having robust arrangements to minimise the risk to the safety of residents. Therefore, a key focus of the January 2022 inspections was a review of the safeguarding arrangements in each of the centres. Safeguarding concerns in centres on the Ard Greine Court campus and in another community-based setting had already been identified through inspections in the latter part of 2021, and inspectors were monitoring the provider's response to those concerns.

On the January 2022 inspections, inspectors reviewed all current safeguarding records, incident reports and residents' records in each of the 18 centres as well as meeting with staff and management about safeguarding arrangements.

During these inspections, inspectors did not identify any current safeguarding concerns that were not being managed and responded to in line with the provider's safeguarding policy. As a result, the Chief Inspector did not need to escalate any safeguarding concerns over the course of this inspection programme. However, inspectors did find gaps in the safeguarding arrangements which the HSE needs to address to ensure proper oversight and response to issues that may arise in the future.

The provider had a safeguarding policy and procedures which were in line with the HSE's national safeguarding policy. In addition, inspectors reviewed intimate care arrangements which are an essential safeguarding issue, and found that there was a policy and procedure for intimate personal care. Inspectors reviewed a sample of the intimate care plans and found that they were appropriate to the resident and were being implemented by staff.

Incidents of a safeguarding nature can arise in any centre and inspectors found that where they arose in these centres, there was an appropriate response in line with the provider's procedures. Any incidents were reported to the relevant statutory authorities where appropriate.

Over the course of the inspection programme, inspectors spoke with 80 staff members and found that they had received safeguarding training and were

knowledgeable about the safeguarding process, how to identify abuse and about safeguarding plans for residents in their centres.

Inspectors found that, in general, there were safeguarding plans in place for residents who required them; however, some plans required more specific detail about the actual safeguarding risks to better guide care and support. In one centre, a resident's safeguarding plan did not include associated safeguarding risks which the resident's family had informed staff about in 2020. Staff and management in the centre did not know whether the CHO1 Safeguarding and Protection Team had been made aware of these further risks and there was nothing in the resident's file to indicate this. The provider's audits had not identified this gap.

In another centre, the provider had put a process in place to ensure that all staff had familiarised themselves with the safeguarding plan for a resident. However, the provider had not ensured that all staff had signed the plans as required by their own process to confirm that they understood the interventions that they were required to implement. These deficits created a risk that staff supporting residents would not be aware of all of the safeguarding risks and about the actions required to minimise further safeguarding concerns. Furthermore, the provider could not assure themselves that staff had familiarised themselves with the plan. This gap had not been identified as an issue in the auditing process.

Persons in charge described the National Incident Management System (NIMS) which they used for escalating significant safeguarding risks. The NIMS process required persons in charge to categorise safeguarding incidents as 'category 3' being the lowest risk, 'category 2' being a moderate risk and 'category 1' being a high/major risk. Category 1 and category 2 incidents were to be escalated to senior management.

However, when inspectors reviewed the NIMS reports they found that, in general, safeguarding incidents were being categorised as the lowest risk — category 3. This meant that the frequency of incidents of a safeguarding nature were not always captured or escalated to senior management.

For example, in one centre, the inspector saw records of an ongoing safeguarding issue where there was a series of what were considered 'lower level incidents' but, due to the ongoing nature, they were having a significant impact on residents. While there was a safeguarding plan being implemented by staff, this issue had not been escalated because the person in charge told inspectors that it did not meet the NIMS criteria.

In another centre, inspectors saw a person in charge going outside process to raise an incident to category 2 so that the incident could be escalated, even though the

person in charge said that it did not meet criteria for escalation to senior management. Inspectors reviewed that incident and found that it was an incident that warranted escalation to senior management. However, escalation only occurred because the person in charge recognised the seriousness and went outside process. Other persons in charge and Directors of Nursing/Area Coordinators told inspectors of other examples where a similar approach was taken.

The provider had implemented a policy and procedures in 2019 on how to ensure safety of residents while accessing online content. However, in five centres inspectors found that there had been no risk assessments completed even though residents were accessing the Internet. Staff had limited or no knowledge about this policy and procedure. The unsafe use of the Internet had been a major issue in one centre in July 2021 and the provider had not taken any measures to ensure shared learning from that incident and to ensure the implementation of the procedures in their other centres. In addition, this failure to implement the policy and procedure and the subsequent risks that could arise had not been identified as an issue in the provider's auditing programme.

The provider had appointed designated safeguarding officers in each centre to respond to suspicions or allegations of abuse. However, in 12 centres inspected in January, the designated safeguarding officer role was fulfilled by the person in charge. The provider was heavily reliant on the person in charge to recognise, identify and respond to safeguarding issues within their own centres. There was inadequate oversight of this role, and these arrangements also created a potential conflict of interest, with persons in charge responding to allegations within their own service and own staff team. This was a particular concern given that a serious safeguarding incident had occurred in a centre July 2021 and in 2017 where the person in charge at that time had not appropriately escalated the concern and had not put appropriate arrangements in place in response to the safeguarding incidents

Persons in charge informed inspectors that safeguarding review meetings occurred to provide monitoring and oversight of safeguarding concerns. However, inspectors reviewed a sample of the minutes of these meetings and found that there was limited trending of incidents — such as, looking at the types of incidents occurring and whether there was any increase or decrease in the number of allegations — and there was no review of the effectiveness of safeguarding plans.

In summary, inspectors did not identify any current safeguarding issues that were not being appropriately responded to. However, the gaps in safeguarding arrangements increased the risk that there would not be an appropriate and timely response to safeguarding issues that may arise.

In order to proactively protect residents, the HSE is required to ensure its policies and procedures are implemented by all staff. The HSE is also required to ensure that persons in charge are provided with clear guidance regarding the reporting arrangements and thresholds for reporting. The HSE needs to review its auditing and oversight arrangements to ensure that risk is identified and to ensure that the HSE is proactive in continuous quality improvement to evaluate the effectiveness of its protection measures.

Regulation	Judgment
Regulation 8: Protection	Not compliant

Regulation 7: Positive behaviour support

Providing positive support in relation to behavioural presentations by residents is a critical aspect of safeguarding.

During the inspections of centres within the Ard Greine Court campus in 2021, repeated non-compliance was identified linked to the management of behaviours that challenge. These findings have been set out in the published reports of those inspections. The issues related to the incompatibility of residents and how their individual needs were in conflict with each other, which led to increased levels of behaviour and safeguarding related incidents. In addition, inspectors found that not all staff in those centres had up-to-date behaviour management training leading to inconsistencies of approach and a high number of incidents impacting negatively on the day-to-day safety of both residents and staff.

In response to those inspection findings, the provider has been implementing a revised improvement plan in the Ard Greine Court centres. Inspectors are monitoring the implementation and the impact of these actions on the safety of residents through monthly reports from the provider and follow-up inspections to verify that information.

In the January 2022 inspections, inspectors met residents with a range of behaviour support needs. In all cases, inspectors found that staff responded to residents in a kind, respectful and considerate manner. Inspectors reviewed behaviour support plans and found that, overall, residents had support plans that recognised their support needs and persons in charge were ensuring that these were being reviewed regularly.

In addition, inspectors saw evidence of staff implementing strategies to support residents to manage their own behaviours where possible, and were identifying and managing potential behaviour triggers for residents.

Inspectors spoke with staff and found that they were knowledgeable about residents' support needs and how to best support them with anxiety and behaviours of concern.

Inspectors also identified some areas where positive behaviour support could be strengthened. The provider required all staff to participate in a behaviour management training programme to inform their engagement with residents. However, in seven centres where staff were working with residents who required behaviour support interventions, not all staff had completed the provider's mandatory training at the time of the inspection. The persons in charge informed inspectors that there were no specific plans to provide that training.

In one centre, the person in charge told inspectors that all agency staff were required to review and sign a document to confirm that they had read and understood the behaviour plans, but not all agency staff had done this. In another centre, the person in charge had an induction pack for new and agency staff which included information on behaviour support, but when inspectors read this, some of the information was inaccurate and out of date. Another centre had no arrangements to brief new and agency staff on the behaviour support needs of residents.

There was inconsistent access to multidisciplinary support for residents. For example, in one centre there was a significant delay in receiving psychology supports for a resident who engaged in high-risk activity that could affect their safety. While a referral for psychology support for this resident had been made in August 2019, it remained outstanding at the time of inspection, despite the high risk to their safety remaining. In another centre, a resident had been referred to the multidisciplinary team 12 months prior to the inspection in relation to significant ongoing behavioural issues but this support had not yet been allocated.

In summary, residents who displayed behaviours of concern were generally well supported, with behaviour support plans in place. However, the HSE needed to ensure that all staff had up-to-date knowledge, skills and the identified training to support residents with behaviours of concern. In addition, improvements were required in the trending of incidents, and in ensuring residents had access to relevant multidisciplinary supports within appropriate time frames, such as psychology and behaviour specialists. Improvements in these areas would enhance the overall support provided to residents and ensure that consistent supports are provided at all times.

Regulation	Judgment
Regulation 7: Positive behavioural support	Substantially compliant

Residents' lived experiences:

Spending time with residents, hearing what they have to say and observing their day-to-day life in the centre is a critical aspect of every inspection.

In the centres that were already of concern to the Chief Inspector and which had inspections during 2021, significant improvements were required to residents' quality of life and safety and these are set out in previously published reports. These centres were not included in the January 2022 regulatory programme as they had received recent inspections. There will be further inspections of these centres during 2022 to verify whether improvements for residents have been achieved.

In the January 2022 inspections, with the exception of one centre, residents were generally happy in their homes. Over the course of a number of years, the provider had improved the home environment for residents and inspectors saw that residents were comfortable and had personalised their homes.

Inspectors met with 69 residents throughout the two weeks of the January 2022 inspections. Residents interacted with inspectors on their own terms, and some residents were happy to speak with inspectors individually, to talk about their lives and what it was like to live in the centre. Inspectors also observed the day-to-day lives of many residents during these inspections. Overall, residents said that they were happy in their homes, were happy with staff and with the service that they received. In addition, most residents said that they liked their homes and that they felt safe. Some residents spoke with inspectors about how they were looking forward to moving to new homes in the future.

Inspectors saw that residents in one centre, the James Connolly Memorial Residential Unit, continued to live in an institutional setting. Issues relating to the poor physical environment for residents have been identified over a series of previous inspections. While there had been some improvements made to the fabric of the building, it continued to be an old, worn building with significant upkeep and repair issues. Residents lived in a home that had poor standards of communal bathrooms, bedrooms and corridors. For example, on the January 2022 inspection inspectors saw a shower room that flooded every time it was used. This caused water to leak into one resident's bedroom. Any time the shower was used, staff had to go into the resident's bedroom, mop the floor and re-tape the floor-covering to the floor. This issue had been escalated to senior management by the person in charge in April 2020 and had still not been resolved over 18 months later.

Senior management informed inspectors that a programme of urgent maintenance work had been scheduled to commence in that centre in February 2022 following a tendering process; however, the person in charge, staff and residents stated that

they were not aware of these plans. This work would cause disruption to residents' lives in their homes, and it is important they are consulted and informed about any such disruption. The provider has informed the Chief Inspector of its intention to transition all residents from this centre to new homes in the community by the end of 2023.

Residents in one house where there were four shared bedrooms said that they were looking forward to moving to their new home which was under construction. They told inspectors that they would each have their own rooms in their new home. In another house, the provider was progressing with an extension to give residents more space and to eliminate the use of a shared bedroom.

In two centres, residents demonstrated their unhappiness at living together by the manner in which they interacted with each other and the inspectors could clearly see that there were significant compatibility issues. The provider had arrangements to manage behavioural issues and had plans for residents to move to new homes. However, progress on this was slow and residents continued to live in a very challenging environment that impacted on their quality of life.

Inspectors also met residents who had recently moved to a new home. For example, one resident had transitioned from a congregated setting in December 2021 and now had their own home. Inspectors saw that the resident was comfortable and happy in their new home, and records showed that the number of behaviour-related incidents had reduced, which staff attributed to the suitability of their new environment.

Throughout the course of the 18 inspections in January 2022, inspectors met residents who were coming and going to various community activities and appointments; such as reflexology, exercise classes, shopping trips and going for drives. A number of residents attended day services external to the centre and spoke about how they liked this. Inspectors found that staff and persons in charge supported residents to access day services, in line with their wishes and preferences.

Some residents did not have an external day service and were supported by staff in the centre to do activities of their choice. Inspectors saw staff treating residents with dignity and respect and supporting them to make choices about their day. Inspectors met residents who were involved with cooking, watching DVDs and listening to music. In addition, inspectors were informed about how some residents were enjoying the re-introduction of more community activities as the restrictions due to the COVID-19 pandemic had eased.

In another example, inspectors met a resident who had poor mental health at the time of inspection. They observed staff spending time with the resident, such as

singing songs with them, and the resident enjoyed and participated with this interaction. Staff described how they had learned that this resident enjoyed singing, and that staff often used this strategy to help the resident with their low mood.

Residents were found to have access to telephones, personal mobile phones and technological devices such as tablets, which supported them to maintain contact with friends and family. There was evidence that residents' families were consulted with in line with residents' wishes.

In summary, inspectors found that residents were generally content and comfortable in their homes, and that their care needs and choices were being responded to and respected by staff. Where there were issues with premises and incompatibilities between residents, these had been identified; however, they were not always addressed in a timely a manner, which impacted on the quality and safety of care of residents.

Conclusion

Since the commencement of the regulation of centres for people with disabilities in 2013, the Chief Inspector has had to initiate repeated escalated regulatory action in a number of HSE centres in the CHO1 area. Inspection reports have noted sustained improvements in the safety and quality of many CHO1 designated centres, particularly in Co. Sligo where there had previously been significant concerns.

Given the ongoing escalated action and failure of the HSE to implement and sustain improvements for residents in a cohort of centres in Co. Donegal, the Chief Inspector expressed concerns to the HSE at national level about the capacity of the HSE to bring about change and to improve the quality and safety of services in Co. Donegal. A regulatory programme to follow-up on governance and safeguarding arrangements in 18 such centres was completed in January 2022.

On this programme of inspections, inspectors did not identify any current significant safeguarding issues in centres that had not been appropriately responded to. Feedback was verbally given at the end of each inspection to the person in charge and relevant staff.

Overall, inspectors found that most residents lived in pleasant, homely environments and that the centres were being managed by experienced and knowledgeable persons in charge.

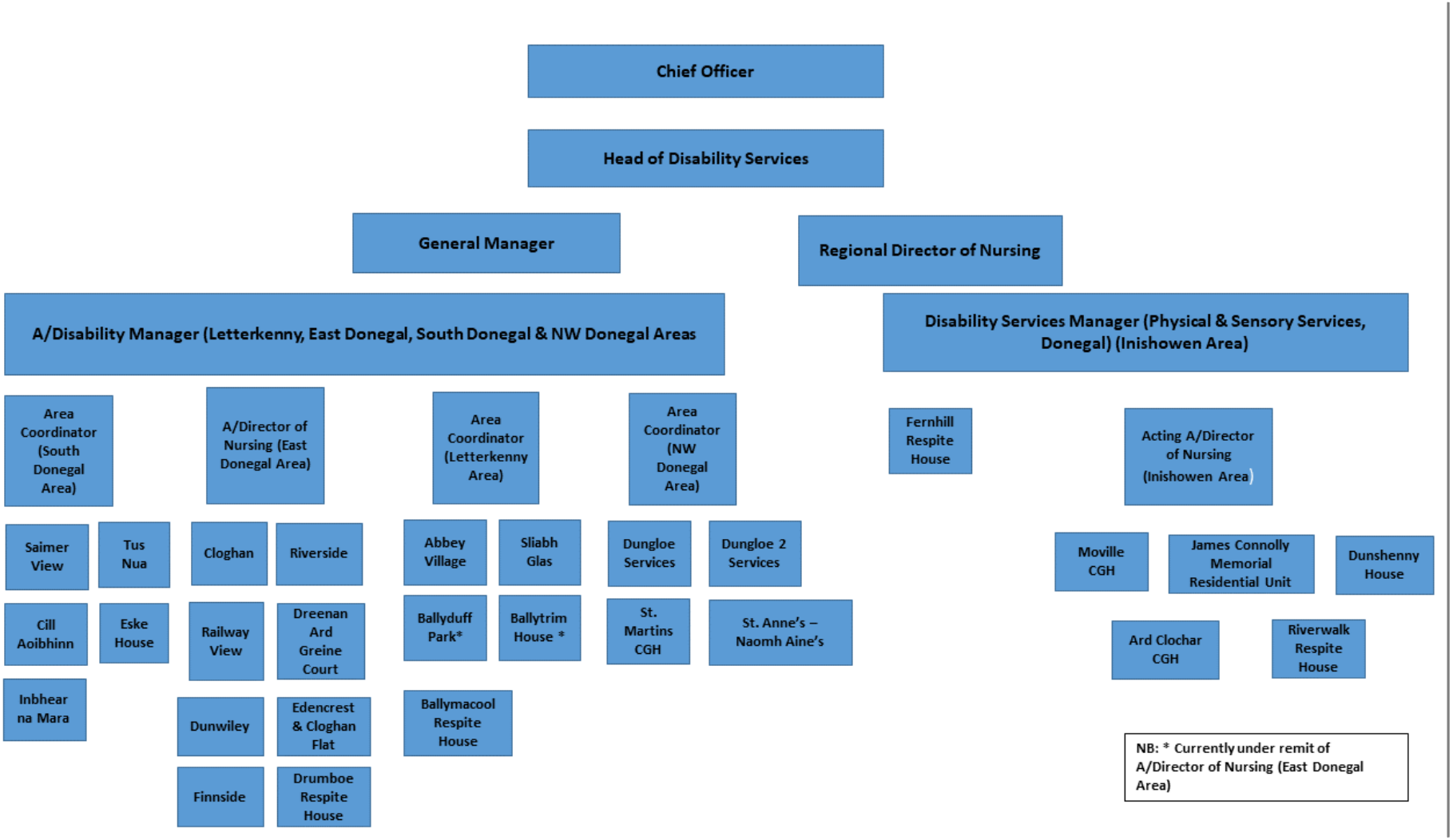
However, inspectors also found that the governance and oversight of centres was poor and the heavy reliance on individual persons in charge to report issues without sufficient accountability and support arrangements in place significantly increased the risk of safeguarding or other issues arising and not being identified and responded to in a timely manner.

Appendix 1 - Regulations inspected under this programme

The inspections that were carried under this programme assessed 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. The table below show the aggregated compliance rating:

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Appendix 2 – Organisation structure of CHO1



Health Service Executive response and compliance plan

This section outlines the HSE's response to the report and the actions they have taken and intend to take.

Compliance Plan, March 2022
in response to the
Overview report of governance and safeguarding in HSE designated centres for people with disabilities in Donegal in January 2022
March 2022

Regulation Heading	Judgment
Regulation 23: Governance and management	**Not Compliant**

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

Senior Management Governance:

- The Chief Officer CHO1 has approved the requirement for an additional General Manager post and an additional Disability Service Manager post for CHO1 Donegal Disability Services in order to enhance governance and oversight in services. These posts will be progressed subject to Department of Health approval.
- The reporting line for CNM3s for Quality, Risk & Service User Safety has been changed from Disability Service Manager to the Regional Director of Nursing (RDON). The reconfigured Quality, Risk and Service User Safety Team lead by the RDON who reports to the General Manager will support external oversight processes in respect of governance and safeguarding in designated centres.

To ensure there is robust oversight of centres with strong governance and management arrangements in place for Donegal Disability Services the following have been undertaken:

- Donegal Disability Management has revised its Terms of Reference which now sets out governance meetings in place for the service. Governance meeting are set out at the following levels:
  A) County level
  B) Network Level
  C) Centre Level

A) County Level

Donegal Regulation, Monitoring & Governance Meeting:

- **Frequency -** Weekly
- **Attendees** – General Manager (chairperson), Regional Director of Nursing, CNM3 for Quality Risk & Service User Safety, Disability Service Managers, Directors of Nursing/Area Coordinators,

- **Purpose -** To support Senior Donegal Disability Management team to implement the required standards in line with regulation and high quality service provision. This includes monitoring of the QIPs that have been identified for weekly monitoring across Donegal Disability Services. This forum also provides oversight of incident management and safeguarding responses in addition to staff training.

- **Donegal Person In Charge (PIC) Meetings**:

Frequency – Fortnightly

Attendees - Rotating chair at Director of Nursing / Area Co-ordinator level, attended by all PICs. Other professionals are invited as required.

Purpose – To ensure appropriate communication pathways between all management levels in County Donegal are in place. In addition this forum will enhance support arrangements, promote shared learning and ensure evidenced based practice with a focus on person centred planning across services. Standard agenda items will include HR/ IR, Estates, Maintenance, Staffing including Agency, Finance, Incident Management and Safeguarding

- **Donegal Disability Governance Meeting**:

Frequency – Monthly

Attendees - Disability Service Managers (rotating chairperson), Directors of Nursing/Area Coordinators, Children's Disability Network Team (CDNT) Managers, HR Manager, Finance Officer, QPS Advisor, and Multidisciplinary staff in Disability Services, Business Manager Disability Services.

Purpose - This meeting is to ensure robust governance across Donegal Disability Services. Standard agenda items for this meeting with oversight of issues that cross over all sections of the service (adults, children, P&S and ID) and specific attention given to Quality & Patient safety, NIMS, Safeguarding, Finance, HR/Staffing, Decongregation, Joint protocol (HSE-TUSLA).

- **Governance for Quality, Safety and Service Improvement Meetings**:

Frequency – Quarterly

Attendees - Disability Managers (rotating chairperson), Business Manager, Directors of Nursing / Area Coordinators, Nurse Practice Development Co-ordinator, CNM3 Quality, Risk & Service User Safety, Children's Disability Network Team (CDNT) Managers, MDT representatives, Safe Guarding representative, QSSI representative.

Purpose - To ensure there are clear structures and processes within Donegal Disability Services to support a quality, safety and service improvement programme.

- **Human Rights Committee Meeting**:

Frequency – Quarterly

Attendees - Disability Managers, MDT representatives, Director of Nursing, external representative and invitees as required. Chairperson agreed by core members and rotated accordingly.

Purpose - The purpose of this meeting is to evaluate the quality and safety of services. To ensure the rights of service users are promoted, protected and supported across all areas of Disability Services in Donegal and to identify opportunities for improvement.

- **Policy Procedure, Protocol, Guidelines (PPPG) Development Group**:

Frequency – Quarterly or sooner if a required need is identified.

Attendees - CNM2s/PICs from across the service and the Practice Development Coordinator (chairperson).

Purpose - Review and develop PPPGs across the service to ensure a consistent service for all. Revised or newly developed PPPGs are escalated for Senior Management approval.

B) Network Level

- **The Governance for Quality Safety Service Improvement Meeting**

Frequency – Quarterly

Attendees - chaired by Director of Nursing / Area Coordinators, CNM2's, CNM3 Quality, Risk & Service User Safety and other professionals as required.

Purpose To ensure there are clear structures and processes at Network level to support a quality, safety and service improvement programme.

- **Safeguarding Review Meeting:**

Frequency - Quarterly

Attendees - Director of Nursing/ Area Coordinator (chairperson), Safeguarding & Protection Team Representative, Social Workers, Psychologists, other relevant MDT Staff, all Persons in Charge.

Purpose – To provide oversight and review of individual safe guarding plans and identify trends and escalate risks as required

C) Centre level

- **Individual Person in Charge (PIC) Meetings with Director of Nursing /Area Coordinator:**

Frequency - Bi-monthly

Attendees - Director of Nursing/Area Coordinator and PIC

Purpose: To review at centre level all operational functions, standards and professional practices with the PIC. Standard agenda items will include incident management, safeguarding, QIP, audits, risk management/escalation, centres' training matrix review, person centred plan review and other priorities as identified by Director of Nursing/Area Coordinator and the PIC. Performance management with each PIC will be a function of these meetings. Formal performance appraisals including Performance Achievement tool will be held with each PIC quarterly.

- **Staff Governance Meetings within Centres**:

Frequency - Bi-monthly

Attendees - Chaired by PIC/CNM2, attended by all staff working within the centre as appropriate.

Purpose – to provide oversight in respect of the standard of care within the centre with a focus on person centred planning for individual residents. Standard agenda items will include review of person centred plans to include behaviour support plans, safeguarding plans, the provision of MDT supports, maintenance, staffing, training and any specific issues relating to the centre.

Audit Review within CHO1:

- A review of audits currently utilised across designated centres is currently being undertaken. This is being lead out by the Regional Director of Nursing CHO1 in conjunction with CNM3s for Quality, Risk & Service User Safety CHO1. An assessment of training requirements in this area will also be carried out with a view to providing the necessary upskilling. This review will be completed by the end of April 2022.
- Support and training will be provided in relation to the completion of 6 monthly unannounced visits/inspections and annual reviews undertaken within designated centres commencing in April 2022 and will be completed by May 2022.
- Director of Nursing / Area Coordinators have implemented the ongoing schedule of visits to designated centres under their area of responsibility as part of the audit process .This will ensure they are aware of risks and provide them with an opportunity to liaise with residents regularly. The detail / information gathered from these visits will be formalized within the minutes and action plan of the monthly Person in Charge meeting.

Regulation 8: Protection	**Not Compliant**

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

To ensure there are comprehensive safeguarding and protective arrangements in place, Donegal Disability Services have undertaken the following:

Safeguarding plans:

- All network areas will have a safeguarding tracking log fully implemented for active safeguarding cases which tracks how the case is managed/closed out. This will be in place by the end of March 2022.
- Incident Management & Safeguarding Training: QPS and Safeguarding & Protection Lead CHO1 will complete joint Incident Management & Safeguarding training with all Persons in Charge. This will be completed by end April 2022
- An additional weekly cross referencing exercise is being currently undertaken by QPS & Safeguarding & Protection Leads to ensure both the Incident Management and Safeguarding Policies are complied with for all incidents.
- The Safeguarding & Protection Team will provide training on preliminary screening to ensure plans are SMART with a focus on vulnerable adults. This training is scheduled to be provided to Persons in Charge, Managers and Directors of Nursing/Area Coordinators and completed by the end of May 2022.

Policy Development:

- A 'Policy on Provision of Safe Wifi Usage' is currently being developed in Donegal Disability Services.

Training:

To ensure all staff have up-to-date knowledge, skills and the identified training required to support residents with behaviours of concern the following are being undertaken:

- Each area has completed a training needs analysis and developed a training schedule to meet the training requirements for 2022.
- As per standard agenda items cited, training schedules will be discussed and monitored at PIC and Centre level meetings.
- The requirement for all staff to read and sign off behaviour support plans will be monitored at centre level.

- Sexuality Awareness in Supported Settings (SASS) training commenced in November 2021 and is currently being delivered to all staff working in designated centres within Donegal Intellectual Disability Services. To date 217 staff have undertaken this programme and training will be offered on an ongoing basis.

- Speakeasy Plus for professionals training programmes x 2 are being run by Health Promotion and Disability Services staff and Safeguarding & Protection Team staff x 24 have secured places on same. The training commenced in March 2022 and runs through to May 2022. This training is designed to provide professionals working in the area of Intellectual Disability an opportunity to develop skills, knowledge and confidence in talking to the people that they support about relationships and sexuality.

Safe Guarding Review Meetings:

Frequency - Quarterly.
Attendees - Safe Guarding and Protection Representative, Director of Nursing/Area Coordinator, Social Work and Psychology Representatives, other relevant MDT staff, all Persons in Charge.
Purpose – To provide oversight and review of individual safe guarding plans, identify trends and escalate risks as required.

Audit:

• A review of the audit schedule and audit tool pertaining to safeguarding currently in use across designated centres is currently being undertaken. This will be completed by end April 2022.

Designated Officer:

• The role of the designated officer across CHO1 will be supported by the implementation of a peer support structure in respect of reporting arrangements and thresholds for reporting. This will be outlined by the General Manager in line with the governance framework at the next scheduled meeting on the 5th April 2022.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support management:

To ensure that there is timely access to quality assessment and intervention & in support of service planning (e.g. decongregation) the following actions are being undertaken:

MDT Supports:

- Approval was again sought and has been provided by the Chief Officer to resource additional MDT supports for residents. 2 x development posts in psychology, social work and speech and language have been approved and will now be progressed for recruitment. The requirement for MDT supports will continue to be monitored and risk assessed in line with available resources and service need. Additional funding to support developments posts identified as a service need will be sought through the budget/estimates process.

Training:

To ensure all staff have up-to-date knowledge, skills and the identified training to support residents with behaviours of concern the following are being undertaken;

- Each area has completed a training needs analysis and developed a training schedule to meet the training requirements for 2022.
- As per standard agenda items training schedules will be discussed and monitored at PIC and Centre level meetings.
- The requirement for all staff to read and sign off behaviour support plans will be monitored at centre level.

Induction Process for HSE & Agency Staff:

- The Director of Nursing/Area Coordinator will review with each PIC the induction pack in place and ensure all information is up to date in relation to their centre. Each new employee will be required to:
    - Complete a schedule of essential mandatory training & have certificates prior to commencing rostered duty.
    - Complete the iStart HSA Induction Programme on HSELand.
    - Complete the site specific induction programme under the guidance of their line manager during the first week of employment and will be provided with a list of additional training to be completed within an agreed timeframe.
    - Complete the Donegal Disability Service Induction Programme.

- An Interim Induction checklist is in place for employees assigned at short notice to a centre. Induction programmes are outlined in each Departmental Safety Statement.
- Compliance with the above is to be monitored at the bi-monthly meeting with the PIC.

Section 2:

Regulations to be complied with

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

Regulation	Judgment	Date to be complied with
Regulation 23	Non Compliant	31/05/22
Regulation 07	Substantially Compliant	31/12/22
Regulation 08	Non Compliant	31/05/22

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