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:	St Martins House CGH
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	25 July 2022
Centre ID:	OSV-0002508
Fieldwork ID:	MON-0033021

About the designated centre

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

St Martins House CGH provides residential care and support to four adults with disabilities. The centre comprises a three bedroom detached bungalow in Co. Donegal and is in close proximity to a small town. The service benefits from having its own mode of transport for access to community-based activities and amenities. Two residents have single occupancy bedrooms while the third bedroom accommodates two residents. Communal facilities include a kitchen-dining room, a small sitting room, a utility facility, shared bathroom facilities, an office and staff bathroom. The centre also has a large private parking area to the front and a private garden area to the rear of the property. The service is staffed on a 24/7 basis and the staff team includes a person in charge, a team of staff nurses and healthcare assistants. All staff have qualifications and in-service training so as they have the knowledge and skills required to meet the needs of the residents in a competent and comprehensive manner.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 25 July 2022	10:00hrs to 17:30hrs	Alanna Ní Mhíocháin	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 of Social Services undertook a review of all HSE centres in that county. This included 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 Health Information and Quality Authority (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 have now commenced 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.

This centre consisted of a small bungalow in a rural town. The house had three bedrooms, one shared bathroom, a living room, a kitchen, utility room, WC and staff office. The centre provided care to four residents. Three residents lived in the centre full-time while the fourth resident availed of shared care and stayed in the centre a few nights per month. This meant that one bedroom was shared between two residents when all four residents were in the centre. This had resulted in disrupted sleep for some residents and there were issues with compatibility between residents. This will be discussed later in the report. The house was clean, tidy and welcoming. Throughout the inspection, it was noted that radios and televisions were tuned to stations of the residents' choosing. The house was personalised with the residents' photographs. A resident had recently celebrated a birthday and there were balloons and birthday cards in the centre to mark the occasion. Tracking hoists had been installed in the ceiling of two bedrooms and the shared bathroom. The bathroom had a shower tray. One resident also had a shower chair. It was noted that the size and layout of the house was not suited to the needs of residents. The provider had committed to sourcing alternative accommodation for the residents by the end of the year. This will be discussed in another section of the report. Outside, it was noted that the external paint was chipped and flaking in places. The house was accessed via ramps at the front and back door. There was a shed that was used to store stocks of personal protective equipment (PPE), continence wear and cleaning supplies. There was a garden to the rear of the house that had a gazebo and benches for sitting out. There was a raised flower bed that had been installed by a local group and which the residents tended with the support of staff. The person in charge reported that all of the garden was not fully accessible to all residents. Previous plans to address this issue were not going to go ahead in light of the provider's plan to find new accommodation for the residents.

The inspector had the opportunity to meet with three of the four residents on the day of inspection. Residents communicated with the inspector with the support of staff. One resident talked about the food that they would like that evening for dinner. Another was noted enjoying music in the living room. One resident's specialised wheelchair had broken on the morning of the inspection and staff had lodged an emergency call to have it repaired that day. It meant that the resident was unable to get out of bed during the time that the inspector was in the centre. It was noted that staff frequently checked with the resident, chatted with them and provided entertainment with television and computer tablets while awaiting the repair of the chair. Staff were caring and respectful in their interactions with residents. One staff member was observed singing and dancing with a resident. Staff were knowledgeable on the needs of the residents. They understood if residents were happy or becoming distressed and responded promptly if the residents required assistance.

Overall, residents in this centre were treated with dignity and respect. Staff were knowledgeable on the residents' needs and preferences and provided good quality care to residents. The centre itself was not suited to the residents' needs due to its small size and layout. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

As outlined above, the provider had submitted a compliance plan in response to the findings from the targeted inspections in January 2022. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in the centre. This included the introduction of regular meetings within the centre and across the service in the county. The person in charge gave information on these meetings and the inspector had the opportunity to review minutes from some of the meetings.

Within the centre, staff governance meetings occurred every two months. The person in charge reported that a local community hall was used to facilitate the attendance of as many staff as possible. The person in charge also requested the attendance of a clerical officer to take minutes. Minutes from the meeting were available for all staff to read and sign. The inspector reviewed the minutes from the meeting held on 25 May 2022 and noted that issues relating to the care and support of residents were discussed. The meeting also included operational issues relating to the running of the centre, for example, staffing. The meeting included a section that requested the input from residents. The inspector also reviewed the minutes of the meetings that took place between the person in charge and the area coordinator. These meetings occurred on the last Friday of every month with the area coordinator attending the centre for these meetings. All agenda items that were

outlined on the provider's compliance plan were included in the meeting's minutes.

The meetings outlined in the compliance plan had commeneced across the network and county. Information from senior management meetings that was relevant to the centre was shared with the person in charge at the monthly meetings with the area coordinator. The person in charge reported that the meetings that they attended in person were useful for sharing information and learning between centres. These included the fortnightly meetings between persons in charge, the network safeguarding review meeting, and the quality safety service improvements meetings. The person in charge gave examples of service improvements that had been implemented through the new meetings structures. For example, the Policy, Procedure, Protocol, Guidelines Development group had approved a new protocol that enabled trained nurses in the centre to check percutaneous endoscopic gastrostomy (PEG) tubes that had been changed. Also, the decongregation plan for the centre had been escalated and developed through the Donegal Disability Governance group.

The compliance plan also outlined that a review of the audits used in the region would be undertaken. It was planned that this would be complete by the end of April 2022. The person in charge reported that they had been informed that the audit tools had been reviewed. However, the new audit tools and schedule had not yet been commenced in the region. The inspector reviewed the existing audit schedule in the centre. It was noted that audits had been completed in all areas that had been identified by the provider. However, these audits were not always completed in line with the schedule. For example, the audit of accidents, incidents and near misses had been completed for the first quarter of 2022 but there had been no audit in the second quarter. The person in charge outlined how issues identified on audits were escalated and addressed. The centre had a quality improvement plan and audit findings were added to this plan with identified actions and time frames for their completion. The quality improvement plan also included actions from the provider's annual review and six-monthly unannounced audits into the quality and safety of care and support in the centre.

There were clearly-defined management structures in this centre. Issues could be escalated to the person in charge and onwards to more senior management, as required. Staff in the centre received supervision from the person in charge. The person in charge had a schedule in place to plan staff supervision sessions. In addition, the person in charge received supervision from their line manager.

The staffing arrangements in the centre were reviewed. The person in charge maintained a planned and actual staff roster. The number and skill-mix of staff were appropriate to the needs of residents. Nursing support was available at all times in the centre. There were adequate numbers of staff employed to cover staff leave, ensuring continuity of care for the residents. The staff training records were also reviewed. The provider had identified a number of mandatory training modules for all staff. Records indicated that most staff were up to date in their training in these modules. In some cases where staff required refresher training, this had been identified by the person in charge and training sessions were scheduled for those staff members. Sexuality awareness in supported settings (SASS) was identified in

the provider's compliance plan as a module that was required by all staff working in designated settings in Co. Donegal. Three members of staff were trained in this module and other staff were scheduled to receive training in September 2022. It was noted that staff were not trained in all areas of care that were relevant to the residents in the centre. For example, not all staff were trained in the administration of emergency medication in the event of a seizure. This posed a risk to residents when a trained member of staff was not available. This will be discussed later in the report. In addition, some residents had recommendations in place regarding modified consistency diets. However, staff had not received training in this area. This had not been identified as a training need by the person in charge.

Overall, the inspector found that the staffing arrangements and skill-mix in this centre were appropriate to meet the needs of residents. There was good oversight and management in this centre. However, some improvement was needed to ensure that audits were completed in line with the provider's schedule and that staff were trained in all relevant areas of care.

Regulation 15: Staffing

The person in charge maintained a planned and actual staff roster in the centre. The number and skill-mix of staff in the centre were adequate to meet the assessed needs of residents. There was a consistent team of staff in the centre to ensure continuity of service to the residents. Nursing staff was available at all times in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified a number of mandatory and site-specific training modules for staff in this centre. Records indicated that staff were mostly up to date with training in these modules. In some cases where refresher training was required, the person in charge had identified dates for the completion of this training and staff were booked on refresher courses. However, training had not been provided in all areas of care identified on inspection. For example, a number of residents had identified needs in relation to their swallowing but training in this area had not been completed by staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO1. At the time of inspection, the 10 actions relating to governance meetings had commenced. The action relating to audit review was in process but had not yet been completed.

In relation to the governance meetings, the person in charge said that the meetings between all persons in charge and the network Safeguarding Review Meeting were beneficial for shared learning between centres. Information from senior management meetings was disseminated to the centres through the meetings between the person in charge and area coordinator.

The planned audit review that was due for completion in April 2022 had commenced but the project was not yet complete. The person in charge reported that the audit tools had been reviewed and updated. However, the schedule for these audits had yet to be completed and, therefore, the roll-out of the new audits had not yet occurred.

In this centre, audits were completed to identify areas for service improvement. However, audits were not always completed in line with the provider's schedule. Actions from these audits were included in the centre's quality improvement plan and were given specific dates for completion. There were clear management structures and lines of accountability in this centre. The provider had completed six-monthly unannounced audits and an annual review into the quality and safety of care and support in the centre in line with the regulations.

Judgment: Substantially compliant

Quality and safety

There was good practice in this centre in relation to the quality and safety of care provided to residents. Residents' needs were assessed and supports were put in place to meet those needs. Safeguarding plans and behaviour support plans gave guidance to staff on how to protect residents. However, the centre was not suited to the needs of the residents. In addition, improvement was required in relation to risk management and ensuring that staff had all the necessary information to support residents appropriately.

As outlined above, the centre was not suited to the needs of the residents due to its layout and small size. The shared bedroom was not in line with the residents' assessed needs. Though the centre had level access flooring and ramps, the narrow doorways and corridors meant that the centre was not fully accessible to all residents. This had been identified on previous inspections. The provider had

committed to renovating the centre to address this issue and a restrictive condition had been placed on the centre that required the provider to come into compliance with the regulations. It had recently been identified that renovations were not possible in the centre. The provider submitted an application to vary the restrictive condition as an alternative decongregation plan had been devised. This plan identified alternative temporary accommodation for the residents that is more suited to their needs and the provider committed to completing this plan by 31 December 2022.

The inspector reviewed a sample of the residents' personal plans. An assessment of the residents' heath, social and personal care needs had been completed within the previous 12 months in line with the regulations. From this assessment, care plans that gave clear guidance to staff on how to support residents with their needs had been devised. The plans were reviewed and updated regularly. In addition, the plans and residents' goals were reviewed annually with input from the residents' family members. This annual review assessed the effectiveness of the residents' personal plans and set new goals for the coming year.

There was evidence in the residents' plans that, overall, their health needs were well managed. Residents had a named general practitioner (GP) and they had an annual medical check-up. Residents were referred to healthcare professionals as required. However, access to these professionals was not always available. For example, one resident had been identified as requiring the support of a speech and language therapist to assist them with their communication. A referral had been made in June 2021 but there had been no follow-up on this issue in the intervening period. Where access to healthcare professionals had occurred, specific programmes and recommendations were included in the residents' plans and there was evidence that these programmes were implemented by staff. For example, one resident had a programme of daily physiotherapy exercises and staff kept a record indicating that the exercises were completed in line with this programme.

Some of the residents' personal plans contained behaviour support plans. There was evidence of input from relevant healthcare professionals in the development of these plans. The plans gave clear information so that staff could identify when residents were calm and when they were becoming upset or anxious. The plans also outlined the strategies that should be used to support residents manage their behaviour and staff were knowledgeable of the steps that should be taken to support residents.

Positive behaviour support was also part of the provider's compliance plan. This plan outlined that staff would be required to read and sign-off on behaviour support plans. In this centre, though staff were knowledgeable on the content of the plans, there was no staff sign-off sheet available on the day of inspection. The person in charge reported that the appointment of additional multidisciplinary team members was in process. In relation to staff induction, the person in charge reported that no new staff members had started in the centre in the previous six months. However, the standard induction pack had been discussed with the area coordinator and the person in charge had included centre-specific information in the pack; the emergency evacuation plan for the centre, residents' behaviour support plans and

safeguarding plans.

The provider had also commenced a number of the actions relating to safeguarding that were identified in the compliance plan submitted following the targeted inspections in January 2022. The person in charge had received incident management and safeguarding training and had also received training on preliminary screening. A safeguarding log was in place in the centre. The log was reviewed monthly by senior management and returned to the person in charge with identified actions for completion, if required. The safeguarding log was also cross-referenced with the incidents reported in the centre and this was submitted to the safeguarding team. Again, actions and target dates for completion were identified and returned to the person in charge. There were plans for four additional designated officers in the network to be trained in the coming months. The person in charge said that staff nurses in the area had been identified for these roles and that they would be given training in incident reporting and safeguarding in September and October 2022.

Within the centre, the provider had taken steps to reduce negative interactions between residents. There had been a visit to the centre on 21 July 2022 by the safeguarding officer and social worker to give advice on open safeguarding issues. There was a safeguarding plan in place and the number of incidents had reduced in recent weeks.

Residents in this centre had specific requirements in relation to their food and nutrition. There was good practice in the centre in relation to the storage and preparation of food in line with the identified nutritional needs of residents. Residents who required non-oral feeding had detailed plans in place and were regularly reviewed by dietetics. Some residents also had recommendations in place regarding their swallow safety. However, the information for staff in this area required improvement. Recommendations made by a speech and language therapist regarding modified consistency diets had not been updated for one resident since 2019. A definition of the specific food consistency was not available in the residents' care plan to guide staff on how to prepare food to the appropriate consistency. Also, as mentioned previously, staff were not trained in supporting residents with swallowing difficulties. Therefore, it was unclear if food was always prepared to the correct consistency for residents. Without training or information in the care plan, it was not clear if residents were assisted in an appropriate manner.

Risk assessments in the centre were reviewed. The person in charge maintained a risk register that outlined risks to the service as a whole. The risk assessments were specific to the centre and to the service. They identified the risks and the control measures that should be implemented to reduce the risk. The assessments were regularly reviewed. A number of individual risk assessments for residents were also reviewed. These also identified relevant risks and control measures. However, not all risks identified on inspection had a corresponding risk assessment. For example, there was no assessment regarding the risk to residents when in the care of staff who were not trained in the administration of emergency medication for seizures. In addition, risk assessments were not always updated in line with the provider's own

guidelines.

Overall, residents in this centre were in receipt of a good service. They were supported to achieve their personal goals. However, the centre was not suited to their needs and improvements were required in risk management and access to information from healthcare professionals.

Regulation 17: Premises

The premises were not suited to the needs of residents. The building was not accessible to all residents. The use of a shared bedroom was not in line with the assessed needs of residents. The provider had submitted a plan that had identified alternative temporary accommodation for the residents that was in line with their needs and had committed to facilitating the move to this new building by 31 December 2022.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents had access to food, refreshments and snacks. Food was stored appropriately. Staff were knowledgeable on the recommendations that were in place for residents in relation to special dietary requirements and modified consistencies. However, there was insufficient information to guide staff on the types of food that were safe for residents and on how to appropriately support residents at mealtimes.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The person in charge maintained a risk register that identified risks to the service. Individual residents also had risk assessments. These identified the risks and control measures that should be implemented to control the risks. However, not all risks identified on inspection had a corresponding risk assessment and risk assessments were not always updated in line with the provider's guidelines.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social needs were assessed. Corresponding care plans were devised to guide staff on how best to support residents with these needs. Residents personal goals had been identified and there was evidence that progress was being made towards these goals. The residents' personal plans were reviewed annually with input from residents' family members.

Judgment: Compliant

Regulation 6: Health care

Residents had a named GP. They had a medical review on an annual basis. There was evidence of input from healthcare professionals. However, not all identified health needs had been fully assessed by relevant health professionals. For example, residents had not been able to access the services of a speech and language therapist in relation to their communication needs.

Judgment: Substantially 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 multidisciplinary team 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 five of these actions on the day of inspection. Three of these actions had been completed. The other two actions were not yet complete.

- The inspector found that the multidisciplinary posts were in progress and that persons in charge were informed of the progress regarding these posts.
- Staff training was included as an agenda item in meetings in the centre.
- The person in charge reported that they had given feedback on the training needs of staff in the centre. However, a formal training needs analysis in the centre had not taken place.
- The staff induction programme had been discussed with the area coordinator and centre-specific modules added to the standard induction pack.
- There was no staff sign-off sheet for the behaviour support plans in the

centre.

In the centre, the person in charge had booked dates in July and August 2022 for staff to receive training in supporting residents manage their behaviour. Residents had behaviour support plans with input from relevant healthcare professionals.

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 of the actions on this inspection. Seven of the actions were complete.

- The person in charge had completed incident management and safeguarding training.
- The person in charge had received training regarding preliminary screening and safeguarding plans
- A network safeguarding tracking log had been implemented.
- Incidents in the centre were cross-referenced against safeguarding plans.
- Training schedules were included as agenda items in the minutes of governance meetings.
- The network safeguarding review meetings had commenced.
- One staff member had received Speakeasy Plus training.

Five of the actions had commenced but were not yet complete.

- Three staff had received training in SASS. Additional training was planned for August 2022.
- As mentioned previously, the review of the audit schedule and tool relating to safeguarding had been commenced. The person in charge reported that the audits had been reviewed but that the schedule of audits had not yet been finalised. As a result, the new audits had not been rolled out across centres.
- The person in charge reported training that was requested by staff to senior management. However, as outlined previously, a formal training needs analysis had not been completed.
- There were plans for four staff nurses from the area to be trained as designated officers. This was due to commence in September 2022.
- The policy for the provision of safe Wi-Fi usage was in process.

One action had not been completed.

- There was no staff sign-off sheet for behaviour support plans in the centre.

There were good safeguarding practices in the centre. Safeguarding plans were in place where needed and staff were knowledgeable of the steps that should be taken if they had any safeguarding concerns. All staff had received training in safeguarding. Incidents were recorded and escalated. Incidents were reviewed and analysed to identify trends.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for St Martins House CGH OSV-0002508

Inspection ID: MON-0033021

Date of inspection: 25/07/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with regulation 16 Training & Staff Development the following actions has been taken · The Person in Charge has arranged training for nine staff to completed Studio 3 2 day training Managing Behaviours of concern. The Person in Charge has scheduled 2 remaining staff for same. Completion Date: 07/10/ 2022. · The Person in Charge arranged training (FEDS) in relation to managing feeding, eating and swallowing for people with an Intellectual Disability on HSELand. Completed: 18/08/2022 · The Person in Charge is scheduled to complete CPR Training. Date: 05/092022	
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 has been taken · The Regional Director of Nursing in conjunction with staff across the CHO 1 continue to	

review audits for the service. The annual schedule of audit fro CHO1 has been reviewed and circulated. The Person in Charge has implemented the schedule within the centre and staff have been updated in relation to same. Audits will be undertaken in line with the revised schedule. Completed Date: 08/08/2022

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: To ensure compliance with regulation 17 Premises the following actions has been taken · The Service manager has submitted an Application to Vary to the Authority for St Martins for alternative accommodation within the Dungloe area. Completed Date: 31/12/2022 · The Person in Charge has completed a risk assessment for the current premises at St. Martins with control measures in place which are kept under constant review. Completed Date: 24/08/2022	

Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: To ensure compliance with regulation 18 Food and Nutrition the following actions has been taken · The Person in Charge has arranged training for staff to complete FEDS training on HSEland Completed Date: 18/08/2022 · The Person in Charge submitted a referral for one resident on 15/08/2022 to attend SALT and Dietitian for review Completion Date: 31/10/2022	

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure compliance with regulation 26 Risk Management the following actions has been taken

· The Person in Charge has reviewed the risk register to ensure all risks have been included.
· The Person in Charge and nursing team has reviewed with GP the resident's requirement for buccal midazolam when on transport. Completed Date: 23/08/2022

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
To ensure compliance with regulation 6 Health Care the following actions has been taken:

· Two WTE Senior SLT posts have been approved for Donegal Adult Disability Services and is currently at the recruitment stage.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To ensure compliance with regulation 7 Positive Behavioural Support the following actions has been taken

· The person in Charge has arranged training for nine staff to completed Studio 3 2 day training Managing Behaviours of concern. Completed Date 18/08/2022
· The Person in Charge has scheduled 2 remaining staff for same. Completion Date: 07/10/ 2022.
· The Person Charge has implemented a staff sign sheet for one residents positive behavioral support plan for staff to read and sign. Completed Date: 04/08/2022
· The Person in Charge has completed a training needs analysis for the centre. Date completed: 04/08/2022

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance with regulation 8 Protection the following actions has been taken

· The Person Charge has implemented a staff sign sheet for one residents positive behavioral support plan for staff to read and sign. Completed Date: 04/08/2022
· The person in Charge has arranged training for nine staff to completed Studio 3 2 day training Managing Behaviours of concern.
· The Person in Charge has scheduled 2 remaining staff for same. Completion Date: 07/10/ 2022.
· The Person in Charge has nominated staff to complete Designated Officer training. Completion Date: 17/10/2022
· Donegal Disability Service is currently developing a policy on the provision of safe Wifi usage in conjunction with the Digital Health Lead, Health and Social Care Professionals and in consultation with other care group services. Completion date: 31/12/2022

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	07/10/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2022
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Substantially Compliant	Yellow	31/10/2022

	are consistent with each resident's individual dietary needs and preferences.			
Regulation 18(3)	The person in charge shall ensure that where residents require assistance with eating or drinking, that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.	Substantially Compliant	Yellow	18/08/2022
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 safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	08/08/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	23/08/2022

Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	31/12/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	07/10/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	04/08/2022