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:	Hawthorns
Name of provider:	Health Service Executive
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	26 February 2024 and 27 February 2024
Centre ID:	OSV-0003359
Fieldwork ID:	MON-0042890

About the designated centre

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

Hawthorns provides residential care for up to 16 adults, both male and female, with an intellectual disability. The centre consists of five detached bungalows and a self-contained apartment on a campus setting with green areas to the back and front. Each bungalow has an open plan living room with a defined dining area. Each home has a kitchen, a utility room and laundry facilities. Each resident has their own bedroom and access to a number of bathrooms. The centre is in a suburban area of Dublin close to a local village with easy access to shops and other local facilities. The centre is close to public transport links including a bus and train service which enables residents to access local amenities and neighbouring areas. Residents are supported by a staffing team 24 hours a day seven days a week and the team comprises of a person in charge, clinical nurse managers, staff nurses and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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 26 February 2024	14:00hrs to 21:00hrs	Marie Byrne	Lead
Tuesday 27 February 2024	09:30hrs to 16:00hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

Overall the findings of this inspection were that this was a well-managed and well-run centre. A number of residents told the inspector of social services they were happy and felt safe living in the centre. The provider had good systems for monitoring the quality of care and support in the centre and were identifying areas where improvements were required and developing and implementing action plans. In line with the findings of this inspection, the provider had found that further improvements were required in relation to staffing numbers, staff training, continuity of care and support for residents, and the availability of suitable transport in the centre.

This was an unannounced risk-based inspection, which was completed following receipt of two pieces of unsolicited information in the form of a concerns received by the Chief Inspector of Social Services between 2023 and 2024. A provider assurance report was issued to the provider in 2023 in relation to the first piece of unsolicited information and both pieces were used as lines of enquiry for this inspection. The concerns submitted related to residents' rights, safeguarding, staffing and governance and management.

The designated centre consists of five houses and a self-contained apartment on a campus in County Dublin. Residential care is provided for up to 16 adults, both male and female, with intellectual disabilities. Each bungalow has an open plan living room with a defined dining area, a kitchen, a utility room and laundry facilities. Residents have their own bedroom and access to a number of bathrooms. The self-contained apartment contains a large open-plan living space with kitchen and dining facilities, a bedroom and a large bathroom.

There were 14 residents living in the centre at the time of the inspection and the inspector had an opportunity to meet with each of them over the two days of the inspection. Residents in the centre communicated using speech, gestures, facial expressions, body language, and sign language. Some residents spoke with the inspector while others smiled, shook hands, gave them a thumbs up, or used sign language. Overall residents appeared comfortable and content in their homes and in with the levels of support offered by staff. In a number of the houses the inspector was invited to join residents for a drink and a snack. Residents were observed to prepare their own drinks and snacks or to approach staff for support. Staff were observed to be very familiar with residents communication preferences. Kind, caring, warm and respectful interactions were observed throughout the inspection.

The houses and apartment were warm, clean and homely. They each had a welcoming atmosphere. A lot of work had been completed in the houses since previous inspections which had contributed to them appearing more homely and comfortable. Communal areas contained soft furnishings and art work, and residents now had more access to shared spaces including a space to spend time alone or with their visitors. Residents' bedrooms were personalised to suit their tastes and

contained sufficient storage for their personal belongings. They had their favourite items on display, including photos of them and the important people in their lives.

Residents in some of the houses showed the inspector around their home. They spoke about their favourite parts of their homes and showed them their favourite possessions. A number of them spoke about their love of sport, animals, music, shopping, and spending time with their family and friends. A number of residents spoke about how important their independence was to them and how supportive staff were in helping them to take the necessary steps to become more independent. For example, one resident spoke about the steps they were taking to use public transport and access their local community independently.

Residents spoke about how they liked to spend their time and what they found relaxing. They spoke about going to day services and taking part in their preferred activities in their local community. At times during the inspection residents were out and about in their local community when the inspector visited their home. They were attending appointments, gone to day services, gone to the pub, meeting friends for coffee, attending a local advocacy group, or gone for a walk or a drive with staff. Examples of activities residents were regularly taking part in at home included horticulture, cooking, exercise classes, music, and arts and crafts. Over the two days of the inspection, residents were observed laughing and joking with staff, watching television, listening to music, singing and dancing, having meals and snacks at a time that suited them, getting up and going to bed at a time that suited them, and relaxing in their homes. Residents were also observed taking part in the upkeep of their home.

One resident told the inspector they got great support from staff, particularly when they were unwell. They said they felt "well supported", and in receipt of a "great service". Another residents said they lived in "as lovely house" and described the staff as "lovely". One resident told the inspector "we could do with more staff". They talked about how hard the team were working to make sure the same regular agency staff were supporting them, but added that sometimes there were different agency staff they didn't know.

The provider had a human rights committee in place, which had external representation. Plans were in place for resident representatives to join the committee. Resident meetings were occurring regularly and residents were meeting with their key workers regularly to develop their goals. There was information available in an easy-to-read format on areas such as, healthy eating, safeguarding, advocacy, human rights, infection prevention and control (IPC), and complaints. A number of residents said they were aware of who to go to if they had any worries or concerns.

The inspector had an opportunity to view recently completed relative and friend questionnaires. Overall feedback in these was very positive, particularly in relation to communication, the complaints process, and staff support for their family member or friend. Examples of comments included in the questionnaires were, "… is living an active and interesting life", "thanks to all the staff", "if you have any concerns you can talk to staff who listen respectfully and attentively", "… is treated with dignity

and respect". Where areas for improvement in relation to house decoration and access to activities were identified this had been followed up on by the person in charge.

In summary, residents were keeping busy and had things to look forward to. They were provided with supports to develop and maintain relationships with the important people in their lives and to participate in activities in accordance with their interests. The provider was aware of the areas where improvements were required in relation to the staffing, staff training, and the availability of suitable vehicles in the centre.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspector found that the provider had suitable governance and management arrangements in place to monitor and oversee the quality and safety of care and support of residents in the centre. They were identifying areas of good practice and areas where improvements were required. They were developing action plans with clearly defined actions and time frames for the completion of these actions. They had completed a number of premises works, reduced the number of registered beds in the centre, identified where safeguarding and resident compatibility was impacting the quality and safety of care and support for residents and taken action. There was a clear focus on quality improvement in the centre and in line with the findings of this inspection they had identified that further improvements were required in relation to staffing numbers and continuity of care and support, and the availability of suitable transport in the centre.

The provider had a clearly defined management structure in place which identified lines of authority and accountability. The person in charge was supported in their role by a number of clinical nurse managers, an assistant director of nursing and a director of nursing. There was a management presence in the centre 24/7. The provider had completed an annual review and six-monthly unannounced visits in line with regulatory requirements. These reviews included consultation with residents and their representatives.

The person in charge had a quality enhancement plan which combined the findings and required actions associated with the provider's annual and six-monthly reviews, previous inspection reports, and their local audits and reviews. The majority of actions were progressing as planned, and when it was not possible to progress actions the rationale for this was clearly documented and escalated to the relevant parties as required. The provider had systems to monitor and trend incidents relating to safeguarding, behaviours of concern, accidents and near misses, and complaints. Management and team meetings were taking place on a regular basis

and the agendas were resident-focussed.

In recent years the provider had completed a number of compatibility assessments and reduced the number of residents living in each of the houses. They had also increased staffing numbers in line with control measures listed in safeguarding plans. The inspector found that the provider was aware that the number of staff employed on a full-time basis was not appropriate to best meet the assessed needs of residents. They were ensuring that there were right number of staff on duty in each of the houses both day and night by using agency staff to fill the required shifts. The volume of staffing vacancies in the centre and the over-reliance on agency staff to fill shifts was found to be impacting on continuity of care and support for residents. This is detailed further under Regulation 15: Staffing below.

Staff had access to training and refresher training in line with the provider's policy and residents' assessed needs. However, a small number of staff required training or refresher training. There was a schedule in place for formal staff supervision but some improvements were required in this area. This is detailed further under Regulation 16.

Registration Regulation 8 (1)

The provider submitted the required information with the application to vary condition 1 of the registration of this designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had successfully recruited to fill eight staff vacancies since the last inspection; however, four nursing vacancies and 12 care staff vacancies remained and there were three staff on extended unplanned leave. The provider had completed a number of recruitment drives and held a large volume of interviews. While they continued to try to recruit to fill the vacancies they were covering all of the required shifts in order to implement the control measures listed in risk assessments and safeguarding plans.

There were planned and actual rosters and they were well maintained. From a sample reviewed, on average 40% of shifts were covered by agency staff. The provider was attempting to reduce the impact of staff vacancies on continuity of care and support for residents by booking the same agency staff, where possible. However, due to the volume of shifts requiring cover, this was not always proving possible.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff could access training identified as mandatory in the provider's policies and a number of additional trainings in line with residents' assessed needs. The person in charge maintained oversight of staff training, including the records of agency staff. A list of planned training dates was made available to staff and discussed during staff supervision. Letters were also sent to staff to highlight these and their training needs. 24 staff had completed online training on applying a human-rights based approach to health and social care and members of the management team had completed training on leadership and change management. A small number of staff required refresher training in a number of areas such as fire safety, managing behaviour that is challenging, safeguarding, infection prevention and control, and manual handling.

There was a staff supervision schedule in place in line with the provider's supervision policy and 100% of nurses had supervision in line with the provider's policy on 2023; however, 57% of healthcare assistants had supervision in line with the provider's policy in 2023. The majority of staff supervisions had detailed agendas and varied discussions on staff's roles and responsibilities in relation to residents' care and support; however, some had limited agenda items and did not provide opportunities for discussions about the quality and safety of care for residents in the centre.

Staff meetings were occurring regularly and staff could add to the agenda if they wished to. Staff meetings were held twice and at weekends to facilitate as many staff as possible to attend them.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a directory of residents in place which contained the required information. It was being regularly reviewed and updated.

Judgment: Compliant

Regulation 21: Records

The provider had effective policies, procedures and practices relating to the creation,

maintenance, storage and destruction of records. Records were well maintained and readily available for review during the inspection.

Judgment: Compliant

Regulation 23: Governance and management

The management structure in the centre was clearly defined. The provider had completed an annual review and six-monthly unannounced provider visits in line with regulatory requirements. There were systems to record and track incidents and the required actions were being taken in a timely manner. They were identifying areas where improvements were required in the centre and developing detailed action plans with clear dates to achieve these. These action plans were reviewed at regular meetings between the person in charge and director of nursing.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained the required information and had been updated in line with the time frame identified in the regulations. It was available in the designated centre.

Judgment: Compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents occurring in the centre and the Chief Inspector of Social Services was notified of the occurrence of incidents in line with the requirement of the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies required under Schedule 5 were available and reviewed in line with the time frame identified in Regulation 4.

Judgment: Compliant

Quality and safety

Overall, while residents lived on a campus, it was evident that they were supported and encouraged to engage in activities of their choosing and to strive to have a good quality of life. There were involved in the day-to-day running of their homes, and were supported to understand their rights and what to do if they had any worries or concerns. As previously mentioned the provider had identified the need for new vehicles to fully meet residents' needs.

Residents were actively supported and encouraged to connect with their family and friends and to take part in activities in their homes and in their local community. They were being supported to be independent and to be aware of their rights. They were also supported to access information on how to keep themselves safe and well. Residents were being supported to access day services, where they wished to do so. They had an assessment of need and personal plan in place. These were supported to develop and achieve goals and try different activities to see which they found meaningful. Residents who required positive behaviour support plans had these in place and they were detailed in nature.

The provider had made further improvements to the premises since the last inspection. They had also applied to add a self-contained apartment to the footprint of the designated centre. Overall, there was additional communal space available for residents in some of the houses. Some residents and staff reported delays in getting maintenance works done but overall the centre was found to be in a good state of repair.

The risk management systems in place were ensuring that risks were identified, assessed, managed and reviewed. There were systems for responding to emergencies. Risk assessments were developed and reviewed as required, with some under review at the time of the inspection. Where adverse incidents occurred, they were documented and followed up on. Learning as a result of the review of incidents was shared with the staff team. The vehicles in the centre were identified as a risk on the provider's and local risk register due to their age, mileage and not fully meeting residents needs. This is discussed further under Regulation 26.

Residents were protected by the polices, procedures and practices in place in relation to safeguarding and protection in the centre. Staff had completed training and were found to be knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse. Staffing in the centre was organised to support the implementation of control measures detailed in safeguarding plans.

Regulation 11: Visits

The provider had a visitors policy in place and arrangements for visits was also detailed in the statement of purpose and residents' guide in the centre. Residents were being supported to contact their relatives by phone or video call and could receive visitors if they wished to, and if it did not pose a risk. There were a number of private an communal spaces available for residents to meet with visitors, including a visitors room in each of the houses.

Judgment: Compliant

Regulation 17: Premises

Each of the premises were warm and designed and laid out to meet residents' needs. Significant works had been completed in each of the houses in the years preceding this inspection and these had resulted in residents' homes appearing more homely and comfortable.

Maintenance and repairs were discussed and documented at residents' meetings and following visits to the houses by the person in charge and clinical nurse managers. These were logged and reported to the provider's maintenance department. Overall, the houses were well maintained but residents and staff reported that works were not always completed in a timely manner.

Judgment: Compliant

Regulation 18: Food and nutrition

Significant efforts were being made by the staff team to ensure that residents were involved in shopping, preparing and cooking in their homes if they wished to. There were adequate amounts of food and beverages available in the houses and menu planning was discussed with residents to ensure choice and that wholesome, nutritious meals were on offer at mealtimes. The advice of dieticans and other specialists was being implemented.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents, staff and visitors were protected by the risk management polices, procedures and practices in the centre. The risk register was reflective of the presenting risks and incidents occurring in the centre. There were general and individual risk assessments which were reviewed regularly. Some of these were in the process of being updated at the time of the inspection as the risk ratings were not fully reflective of the existing controls and presenting risks. This particularly related to wearing masks and medication management practices.

The provider had identified that a number of vehicles in the centre needed to be replaced due to their age, and in line with residents' changing needs. This was identified on the the centre and provider's risk register, documented in staff and management meetings, in complaints records, and raised by both staff and residents during the inspection. The inspector was informed that some residents were finding it difficult to access some of the existing vehicles.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had implemented a number of additional controls in response to a trend of medication errors and omissions in the centre. This included bespoke training for staff, a change in practices with two staff involved in the administration and stock checks of medicinal products and the completion of a number of audits. These control measures were proving effective and the local management team were reviewing the control measure relating to two staff at the time of the inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need and personal plan in place. Language in residents' plans was person-first and positively described residents' care and support needs, and their likes, dislikes and preferences. These were being audited and reviewed on a regular basis to ensure they were factually accurate, reflective of residents needs and adequately guiding staff to support them in line with their wishes and preferences. Residents were meeting with their key workers on a regular basis and developing and achieving a number of goals.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to enjoy best possible health. They had their healthcare needs assessed and were supported to access health and social care professionals. Some residents were experiencing difficulties accessing some health and social care professionals but there was documentary evidence to demonstrate the efforts being made to support residents to access these services. Resident's right to refuse medical treatment was respected and documented. Residents are informed of and supported to make decisions about accessing national screening services.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were appropriate supports in place for residents in relation to positive behaviour support. Residents had their needs assessed and behaviour support plans were in place for those who required them. These were detailed in nature and clearly guiding staff practice.

There were a number of restrictive practices in place which were reviewed regularly to ensure they were the least restrictive for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the polices, procedures and practices relating to safeguarding. Allegations and suspicions of abuse were reported and followed up on in line with the provider's and national policy. There had been a trend of allegations in 2022 and 2023 and in response a number of assessments had been completed and additional controls implemented which had proved effective in reducing the presenting risks. Safeguarding plans were developed as required. Staff had completed training and those who spoke with inspector were aware of their roles and responsibilities should there be an allegation or suspicion of abuse.

A sample of residents' intimate and personal care plans were reviewed and found to be suitably detailed to guide staff practice to support residents in line with their assessed needs, and wishes and preferences, while ensuing their privacy and dignity was maintained.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 8 (1)	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hawthorns OSV-0003359

Inspection ID: MON-0042890

Date of inspection: 26/02/2024 and 27/02/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Regulation 15 (1)
• The PIC and Service Provider are actively engaged in a rolling camping to recruit both staff nurses and care assistants to fill any outstanding vacancies within the service- in Hawthorns which is part of South Side Intellectual Disabilities.
• The current campaign for Health Care Assistants Intellectual Disability were interviewed over three days in March (19th, 20th & 21st).It is expected that a number of Health Care Assistants ID would be recruited from this campaign to meet the shortfall.
• The Clinical Nurse Manager 2 Campaign for Hawthorns is currently live on an employment platform for applications for Hawthorns.

The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Regulation 15 (3)
• In the interim period the PIC and the Service Provider are ensuring that only consistent agency staff who have receive a detailed induction in line with their HSE peers are contracted to Hawthorns to fill outstanding vacancies.
• Agency staff are also invited to attend training specific to the Designated Centre (i.e. Studio 3, Autism, Goal Setting, and Incident Report Training). These agency staff are familiar and consistent to the service users. Where as far as possible no AD-HOC agency staff are contracted to work in Hawthorns.
• The PIC and Service Provider will ensure that there is an appropriate skill mix on duty in each house, for instance regular HSE staff and a familiar agency staff will be rostered together until all outstanding vacancies are filled.
• The PIC will ensure that all new staff will continue to receive a comprehensive

induction to the service and be supported while becoming familiar with the needs of the residents and strategies in place to assist them to have a good quality of life.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
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.
• The PIC and the Service Provider has completed a training analysis and the employees who were identified to have outstanding training requirements will received a further letter outlining their responsibilities as an employee to ensure their mandatory and statutory training is in compliance with the Health Care Act, Policy in Mandatory Training, the Health and Safety at Work Act 2005 and the terms and conditions of their contract.
• The letter will include the specific list of courses that requires to be completed.
• The PIC will ensure training is brought to all staff's attention by dissemination of training notices, discussions at staff meeting (26/03/24 and 27/03/24) upcoming training and staff responsibilities to ensure that any outstanding training is completed. The PIC will facilitate staff released to attend training.
• The Pic will ensure the Training Schedule and upcoming training is available and printed and shared with all staff.

Regulation 16 (1)(b) The PIC will aim to improve the quality of supervision sessions in relation to action plan and agenda and ensure that each health care assistant has access to supervision.
• The PIC will aim to improve the quality of supervision sessions in relation to action plan and agenda and ensure that each health care assistant has access to supervision.
• An induction is completed with new staff and subsequently performance management meetings will occur as required.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider shall ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced,

insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

Regulation 26 (2)
• The Risk Register for the Centre is being updated and by November 2024 will be in line with the National Enterprise Policy.
• The PIC has flagged the need for updated vehicles for the center to the Director of Nursing. This is documented in minutes at the Centers Management meetings, Six Monthly Reports, Annual Report and also a complaint was sent to the Director of Nursing. The Director of Nursing has placed this on the Service Risk Register for Southside Intellectual Disability Services.

Regulation 26 (3)
• The PIC will complete a Risk Assessment on the Current Vehicles for the service and this will be sent to the Provider Nominee to be included in the forthcoming Capital List. Risk Assessment completed.
• The outcome of this inspection in relation to the service vehicles was also brought to the attention of the Director of Nursing who is the Service Provider Nominee on 29/03/24.
• The PIC will continue to ensure that the buses are checked by staff and any repairs are completed by the garage and the CRVT will be completed annually to ensure the service vehicles are road worthy.
• All service vehicles in the designated centre are covered by AA Emergency Services in the event of a breakdown or any emergency fault.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/11/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/11/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	31/07/2024

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2024
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	30/11/2024
Regulation 26(3)	The registered provider shall ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.	Not Compliant	Orange	30/11/2024