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:	Ard Clochar Community Group Homes
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	15 November 2022
Centre ID:	OSV-0005248
Fieldwork ID:	MON-0031073

About the designated centre

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

Ard Clochar Community Group Homes provides full-time and shared residential care and support to 14 adults with a disability. The designated centre comprises three interconnected purpose built bungalows. Residents in each bungalow have their own bedrooms with en-suite bathrooms. In addition, residents have access to communal areas in each bungalow which includes a sitting room, kitchen dining room, laundry room and additional bathroom facilities. The centre is located within a residential area of a rural town and is close to local amenities such as shops and cafes. Residents have access to an adapted vehicle at the centre which further enables them to access amenities such as leisure facilities in the surrounding area. Residents are supported by a staff team of both nurses and health care assistants who are available in the centre both during the day and at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 15 November 2022	10:00hrs to 17:10hrs	Jackie Warren	Lead

What residents told us and what inspectors observed

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

At the time of the inspection the provider had implemented a number of actions to strengthen the governance and management. In addition, a number of actions relating to positive behaviour support (regulation 7) and protection (regulation 8) had been completed or were in progress. These will be discussed in the other sections of this report.

This inspection was unannounced and was carried out to monitor regulatory compliance in the centre. As part of this inspection, the inspector observed the care and support interactions between residents and staff. The inspector met with some residents who lived in this centre, spoke with staff on duty, observed interactions between staff and residents, and also viewed a range of documentation and processes.

Residents who lived in this centre had a good quality of life, had choices in their daily lives, were well supported with their care needs, and were involved in activities that they enjoyed. Residents also lived in a comfortable, home-like environment.

The centre consisted of three adjoining and interconnecting houses and could provide full time residential services for up to fourteen adults. The centre was very centrally located, with town facilities such as restaurants, leisure facilities and shops nearby. Transport was available so that residents could go out for drives, shopping, family visits and to attend local amenities.

Suitable facilities, furniture and equipment were provided to meet the needs of residents. Internet access, television, games, and music choices were available for residents' use. There was adequate communal and private space for residents, well-equipped kitchens, laundry facilities and sufficient bathrooms. All residents had their own bedrooms. These bedrooms were comfortably decorated, suitably furnished,

and personalised. The centre had separate gardens for residents' use. These gardens were well-maintained and residents had access to paved areas, seating and raised beds for gardening projects.

The inspector met with five of the fourteen residents who lived in the centre. Two of the residents, who were in the centre having lunch, spoke briefly to the inspector about their lives there, while others preferred not to speak with the inspector. Other residents were not present at the time as they were either at day services or out doing activities in the community. Residents who spoke with the inspector said that they liked living there and that their bedrooms were very comfortable. When the inspector met these residents they were having their lunch which was a home cooked roast dinner. They said that they had enjoyed their meal, that they were always happy with the meals that staff cooked for them and that they were involved in meal choices.

Observations and related documentation showed that residents' preferences were being met. Some of the activities that residents enjoyed included outings to local places of interest, sensory activities, concerts, shopping, beauty treatments and visits with their families.

Overall, it was evident from observation in the centre, conversations with staff, and information viewed during the inspection, that residents had a good quality of life, had choices in their daily lives, and were supported by staff to be involved in activities that they enjoyed, both in the centre, at day service and in the local community.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents' lives.

Capacity and capability

Overall, the provider had measures in place to ensure that this centre was well managed, and that residents' care and support was delivered to a high standard. However, there were some governance deficits which presented a risk that this standard might not be consistently achieved.

The provider had submitted a compliance plan in response to the findings from some 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. These included the introduction of regular meetings within the centre and across the service in the county. The person in charge discussed how the compliance plan was being implemented and explained how improved systems that had been introduced as part of this plan.

Since the previous inspection of the centre in January 2022, significant improvement

to the overall organisational management processes had taken place. These improvements included a range of governance and oversight meetings. For example human rights committee meetings were being held quarterly, and weekly regulation, monitoring and governance meetings took place for Donegal County. The person in charge also spoke of fortnightly meetings with other persons in charge in Donegal, and said that these meetings were a useful format for receiving information from peers and higher management levels, and for shared learning from other persons in charge. Due to work commitments in the centre, the person in charge did not always have the capacity to attend these meetings but acknowledged that the minutes of the meetings were always supplied for her information. She also confirmed that she was kept informed of the outcomes of a range of other management meetings taking place in the area.

There was a clear organisational structure in place to manage the centre. There person in charge was suitably qualified and experienced, was based in the centre, and worked closely with staff and with the wider management team. Throughout the inspection the person in charge was very knowledgeable regarding the individual needs of the residents who lived there. It was clear that the person in charge was very involved in the running of the service and that the residents knew her. The person in charge had a strong oversight of the centre and was also very focused on ensuring that a high standard of care and safety was being maintained through ongoing auditing and review.

Arrangements were in place to support staff and to access the advice from a senior manager when the person in charge was not on duty at weekends and during the night. There were, however, no formal arrangements in place to cover the ongoing daily role of the person in charge during absence such as annual leave. Therefore, during such absences the responsibility for the running of the centre fell to the staff on duty each day in addition to their regular care duties.

There were suitable systems in place for reviewing and monitoring the service to ensure that a high standard of safety and care was being provided and maintained. Unannounced audits of the service were being carried out twice each year on behalf of the provider. These audits identified any areas where improvement was required, and action plans were developed to address these issues. A detailed and relevant audit plan for 2022 had been developed which included a range of audits to review the overall quality of care and safety in the centre. The person in charge and staff were completing these audits in line with this plan. These included monthly audits of fire safety, personal planning, infection control, complaints, incidents and medication. The sample of audits that the inspector viewed reflected a high level of compliance and actions arising had been completed as required. A representative of the provider had also carried out a detailed annual review of the service. The person in charge had developed a quality improvement plan which was used as a basis for ongoing improvements in the centre.

The centre was well resourced to ensure the effective delivery of care and support to residents, although improvements to staffing were required. These resources included the provision of suitable, safe, clean and comfortable environment, and dedicated transport for the centre. A range of healthcare professionals, including

nursing, speech and language therapy, physiotherapy, and behaviour support staff were available to support residents as required. The centre was also resourced with many physical facilities to reduce the risk of spread of infection. These included hand sanitising gels, supplies of disposable gloves, face masks and aprons, cleaning materials and thermometers. The provider had also ensured that the centre was suitably insured.

Staffing levels and skill-mixes were sufficient to meet the assessed needs of residents at the time of inspection, with nursing and care staff available to support residents at all times. Planned staffing rosters had been developed by the person in charge. These were being updated to reflect actual arrangements as required. However, while there were adequate staffing levels on the day of inspection, the overall available staffing level was not sufficient to consistently fill the required roster from the existing staff pool. Agency staff were frequently required to fill the roster and the person in charge was sometimes required to work care shifts to ensure that the required staffing levels could be met. This presented a risk that consistent staff may not always be available to support residents. This also reduced the person in charge's availability to complete governance duties.

A range of training had been provided for staff to enable them to carry out their roles effectively, although some of the training modules required by the provider had not been completed by some staff. A training needs analysis had been carried out to inform the training plan for the centre for 2022, and a matrix for tracking staff training had been developed. The level of compliance with the provider's training plan could not be assessed at this inspection as the computer system where training records were kept was malfunctioning at the time. The person in charge told the inspector that all the provider's required training had not yet been met. The failure to achieve this was attributed to the instability of Internet access in the area for online training, and also the inability to release staff for face-to-face training due to care and support commitments in the centre.

Policies required by schedule 5 of the regulations were available to guide staff and were up to date, in addition to other policies that were relevant to the care of residents. A range of guidance documents, the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the standards made under the regulations were also available to guide staff.

Overall, records viewed during the inspection, such as, personal planning records, were informative and up to date. The provider had developed a directory of residents which included the required information relating to each resident who lived in the centre. There was also an up-to-date statement of purpose which was being reviewed annually by the person in charge, and was available to residents and their representatives. There was a detailed computerised personalised planning and assessment system in place in the service, some staff did not have access to this system. Records from the computerised system were being printed to provide information to these staff. On review it was found that the printed records were not easy to read and the information was not presented as clearly as in the computerised records. This presented a risk that some information might not be

clearly accessible to all staff.

Regulation 15: Staffing

Staffing levels and skill-mixes were sufficient to meet the assessed needs of residents at the time of inspection. However, it was evident from review of information that the overall compliment of staff had reduced and that the provider had not been successful in recruiting replacement staff to address this. This presented a risk that consistent staff may not always be available, which could impact on continuity of care and support for residents.

The following improvement is required:

- ensure that additional staff are recruited in line with the provider's identified staffing requirement
- ensure that the consistency of staff and continuity of care is provided.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Access to appropriate training, including refresher training was provided as part of a continuous professional development programme. The person in charge confirmed that there was a schedule of essential training in place to monitor and plan staff training. However, the person in charge also confirmed that some of the essential training had not been completed as required. Due to a computer malfunction, the training matrix was not accessible to view on the day of the inspection, therefore, the extent of the training deficit could not be established.

The following improvement is required:

- ensure that staff attend all mandatory training required by the provider
- ensure that computer system malfunctions are promptly addressed to provide the person in charge with access to staff training records.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a directory of residents which included the required information relating to each resident who lived in the centre.

Judgment: Compliant

Regulation 21: Records

The provider had ensured that records were maintained in a clear and orderly fashion and were kept up to date. However, staff training records were not available on the day of inspection due to a malfunction in the computerised system. While there was a detailed computerised personalised planning and assessment system in place in the service, some staff did not have access to this system. Records from the computerised system were being printed to provide information to these staff. On review it was found that the printed records were not easy to read and the information was not presented as clearly as in the computerised records. This presented a risk that some information might not be clearly accessible to all staff. Furthermore, some residents' assessments required that food diaries be kept and these were not recorded in sufficient detail to inform further assessment of these residents' nutritional needs.

The following improvement is required:

- ensure that staff training records are available to access in the centre
- ensure that records of any special diets for individual residents are in sufficient detail to enable any person inspecting the record to determine if the diet is satisfactory
- ensure that all staff have access to clear personal planning records to enable them to consistently deliver appropriate care and support to residents.

Judgment: Not compliant

Regulation 22: Insurance

There was a current insurance policy in effect for the service.

Judgment: Compliant

Regulation 23: Governance and management

Overall there were improved leadership and management arrangements in place to govern the centre and to ensure the provision of a good quality and safe service to

residents. However, there were some areas where improvements were required. The areas for improvement related largely to staff training, and support and deputising arrangements for the person in charge, consistent staffing, and suitable maintenance of computerised systems.

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. During this inspection, it was found that all 11 actions had been completed. For example, the provider had established a range of governance meetings which were attended by persons in charge and senior managers, and minutes from governance, quality and safeguarding meetings were being circulated to persons in charge to inform staff practice and to support the person in charge to introduce agreed actions in the centre. During this inspection, it was found that a comprehensive range of audits were being carried out to review the quality of the service and to inform improvements to the service as required.

However, improvements were required in the following areas:

- ensure that consistency of staff and continuity of care is provided
- ensure that suitable deputising arrangements are put in place to cover the absence of the person in charge
- ensure that systems were in place to enable staff to attend required training in a timely manner
- ensure that all required staff training is carried out in line with the provider's training plan for the centre
- ensure that malfunctions to computer system are addressed in a timely manner

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was an up-to-date statement of purpose which was being reviewed annually by the person in charge, and was available to residents and their representatives.

Judgment: Compliant

Regulation 4: Written policies and procedures

All policies required by schedule 5 of the regulations were available to guide staff and were up to date.

Judgment: Compliant

Regulation 14: Persons in charge

The role of person in charge was full time and the person who filled this role had the required qualifications and experience. The person in charge was based in the centre and was very knowledgeable regarding the individual needs of each resident.

Judgment: Compliant

Quality and safety

The provider ensured that residents living at this centre received person-centred support and a good level of care. There were measures in place to ensure that the wellbeing of residents was promoted and that residents' general welfare, and social and leisure interests were well supported. Residents received person-centred care that enabled them to be involved in activities that they enjoyed. However, to ensure the ongoing effectiveness of the personal planning process, some improvements to documentation of personal planning records was required.

Residents were supported to take part in a range of social and developmental activities both at the centre and in the community. Suitable support was provided to residents to achieve this in accordance with their individual choices and interests, as well as their assessed needs.

The centre comprised three adjoining houses in a rural town with a variety of amenities and facilities in the surrounding areas. Although the houses were interconnecting, they were each fully self-contained with separate entrances and facilities. The location of the centre enabled residents to visit the shops, coffee shops and restaurants and other leisure amenities in the area. Transport and staff support was available to ensure that these could be freely accessed by residents. Some of the community based activities that residents enjoyed included visiting families, cinema, bowling, shopping, sports,swimming, going to a gym and going to concerts. While in the centre residents enjoyed gardening, arts and crafts, food preparation and other independent living skills, puzzles and music. The residents liked going out for walks and drives in the local area.

The centre suited the needs of the residents, and was spacious, warm, clean, comfortable and well maintained. During a walk around the centre, the inspector found that communal rooms were decorated in a homely manner with pictures and photos, and comfortable furniture. All houses had well equipped kitchens and dining areas. All residents had their own bedrooms, which were comfortable and personalised. There were adequate bathrooms in the centre to meet the needs of

residents. Bathrooms were spacious, accessible and well-equipped. Bathroom walls were tiled and floors were finished with impervious materials, which could be easily cleaned. The houses also had gardens equipped with garden furniture and planting areas where residents could spend time outdoors. However, although the houses in the centre were well maintained, there were some areas in one house which required fresh paint, and repairs to an internal door which had become damaged.

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. At the time of the inspection, the inspector found that six of the seven actions had been suitably completed.

Although there were no residents in the centre who required support with behaviour, the provider had suitable measures in place for the support and management of behaviour that challenges should this be required.

In response to the targeted safeguarding inspection programme in January 2022, 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. At the time of the inspection, the inspector found that six of the seven actions had been suitably completed, while one was in progress. Additional multidisciplinary team supports had been recruited, were appointed, and were available to residents as required, while one post which had been approved and recruited was not yet in position, but was due to take up the role shortly.

The provider had arrangements in place to safeguard residents from any form of harm. 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. At the time of inspection, 11 of these actions had been completed in respect of Ard Clocher.

The completed actions included development of a safeguarding tracker, completion of a training needs analysis and development of a training schedule for staff and improvement to safeguarding auditing. The development of a policy on the provision of safe wi-fi usage had not yet been achieved, although the management team stated that this was in progress. Due to the malfunction of a computer, the training records were not available to establish if relevant training for both the person in charge and staff had been completed. However, the person in charge confirmed that sexuality awareness in supported settings training had not been completed by all staff. The person in charge acknowledged that it would be difficult to achieve completion of all essential mandatory training for new staff prior to commencing rostered duty.

Comprehensive assessment of the health, personal and social care needs of each resident had been carried out, and individualised personal plans had been developed for all residents based on their assessed needs. However, some residents' assessments required that food diaries be kept and these were not recorded in sufficient detail to inform further assessment of these residents' nutritional needs.

While there was a detailed computerised personalised planning and assessment system in place in the service, some staff did not have access to this system. Records from the computerised system were being printed to provide information to these staff. On review it was found that the printed records were not easy to read and the information was not presented as clearly as in the computerised records. This presented a risk that some information might not be clearly accessible to all staff.

Residents' nutritional needs were well met and suitable foods were made available to meet residents' needs and preferences. Nutritional assessments were being carried out and plans of care had been developed accordingly. Residents' weights were being monitored and support from dieticians and speech and language therapists was available as required. Residents, who chose to, were involved in food shopping and meal planning. They also said that they really enjoyed the meals that were supplied in the centre.

Information was supplied to residents both through suitable communication methods, through interaction with staff and there was also a written guide for residents which met the requirements of the regulations.

Regulation 17: Premises

The design and layout of the centre met the aims and objectives of the service, and the needs of residents. Overall, the centre was well maintained, clean, suitably decorated and comfortably furnished. However some improvement was required in the following areas:

- one bathroom required repainting
- one laundry room required repainting
- a bath which was out of order required to be repaired or replaced
- an internal door, which was damaged, required repair.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' nutritional needs were being supported. Residents who chose to, took part in shopping for groceries. Suitable foods were provided to cater for each resident's assessed dietary needs and preferences.

Judgment: Compliant

Regulation 20: Information for residents

Information was provided to residents. This included information, in user friendly format, about staff on duty each day, residents' rights, how to make complaints, and local events and activities. There was also a residents' guide that included the information required by the regulations.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Comprehensive assessment of the health, personal and social care needs of each resident had been carried out, and individualised personal plans had been developed for all residents based on their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Although there were no residents in the centre who required support with behaviour, the provider had suitable measures in place for the support and management of behaviour that challenges should this be required.

In response to the targeted safeguarding inspection programme in January 2022, 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. At the time of the inspection, the inspector found that six of the seven actions had been suitably completed, while one was in progress. Additional multidisciplinary team supports had been recruited, were appointed, and were available to residents as required, while one post which had been approved and recruited was not yet in position, but was due to take up the role shortly.

Due to the inaccessibility of the computerised training records on the day of inspection it was not possible to establish what training had been completed, but the person in charge acknowledged that it would be difficult to achieve completion of essential mandatory training for new staff prior to commencing rostered duty.

Improvement was required in the following areas:

- ensure all staff have training in positive behaviour support
- ensure the completion of essential mandatory training and have certificates prior to commencing rostered duty

Judgment: Substantially compliant

Regulation 8: Protection

The provider had arrangements in place to safeguard residents from any form of harm. 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. At the time of inspection, the provider had commenced and completed 11 of the actions.

The completed actions included development of a safeguarding tracker, completion of a training needs analysis and development of a training schedule for staff and improvement to safeguarding auditing. The development of a policy on the provision of safe wi-fi usage had not yet been achieved, although the management team stated that this was in progress. Furthermore, some staff had not attended some required training.

In relation to the providers actions plan, the following areas required improvement:

- ensure that a policy on safe Wi-Fi provision is developed
- ensure that staff attend training in sexuality awareness in supported settings.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 14: Persons in charge	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Ard Clochar Community Group Homes OSV-0005248

Inspection ID: MON-0031073

Date of inspection: 15/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with regulation 15:staffing the following actions will be taken: • The PIC will review the centres roster on an ongoing basis to ensure that the appropriate staffing is provided to ensure that resident's needs are met and are compliant with staffing levels identified in Centre's Statement of Purpose. • 2 vacant nurse positions have been offered out to the current nursing panel with no one taking up positions. In the interim these vacancies are being partially covered by a regular agency nurse with the remainder covered by current nursing staff and PIC. • Senior Management are currently working with the Human Resource Department and have attended recent employment fares with further fares planned in an additional efforts to recruit staff to the service. Currently there are weekly telecals with Head HR, Paybill, HOS, GM and Disability Managers to address potential solutions to urgent staffing vacancies. • An on call system is in place to ensure effective governance cover at weekends and evenings. This is updated regularly and communicated to all staff. • Form A's and business cases have been submitted for the replacement of required Health Care Attendants.	
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 and staff development the following actions will be taken: • PIC has reviewed the centres training matrix. A centre training needs analysis has been completed • A training plan has been provided for each member of staff who will have completed all mandatory HSEland training by 30/01/2023 • PIC has contacted trainers in Sexuality Awareness in Supported Settings training to carry out face to face training to be completed by 31/03/2023. • Dates have been scheduled for January 2023 for studio 3 training as one staff member	

requires to undertake same.
• CPR training dates have been scheduled for January to March 2023 with all outstanding training to be complete by 31/03/23.
• Moving and handling training dates have been scheduled for January 2023. This training will be ongoing.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
To ensure compliance with regulation 21: Records the following actions will be taken:

• PIC will ensure that staff training records are available to access in the centre
• PIC will ensure that review of printed records of any special diets for individual residents are in sufficient detail to enable any person inspecting the record to determine if the diet is satisfactory
• PIC will ensure that all staff have access to clear personal planning records to enable them to consistently deliver appropriate care and support to residents.
• Computer system to be reviewed by technicians to identify issues and rectify any faults with system by 28/02/2023.

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 will be taken:

• The PIC will review the centres roster on an ongoing basis to ensure that appropriate staffing is provided to ensure that resident's needs are met and are compliant with staffing levels identified in Centre's Statement of Purpose.
• 2 vacant nurse positions have been offered out to the current nursing panel with no uptake on positions to date. In the interim these vacancies are being partially covered by an agency nurse with the remainder covered by current nursing staff and PIC as above
• Senior Management are currently working with the Human Resource Department and have attended recent employment fares with further fares planned in an additional effort to recruit staff to the service. Currently there are weekly telecals with Head HR, Paybill, HOS, GM and Disability Managers to address potential solutions to urgent staffing vacancies.
• The most senior nurse in charge will deputise in the absence of the PIC with support from the ADON
• An on call system is in place to ensure effective governance cover at weekends and evenings. This is updated regularly and communicated to all staff. All staff have been requested to use same and advised that the PIC as above is not to be contacted when not rostered on duty.
• Form A's and business cases have been submitted for the replacement of required HCA'S.
• PIC as above has reviewed the centres training matrix and has completed a centre training needs analysis. Each staff member has been furnished with outstanding training needs to be completed by end of January 2023 for all HSELand courses with other mandatory training to be completed by March 2023.

• Computer system to be reviewed by technicians to identify issues and rectify any faults with system by 28/02/2023.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance with Regulation 17: Premises the following actions will be taken:

• A new bath has been ordered and is due to be installed at end of January 2023. Once new bath has been installed the bathroom will be painted by end of February 2023.
• Laundry room to be painted by end of February 2023.
• An internal door on date of inspection which was damaged has since been replaced. This was completed at end of November 2022.

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 behavioral support the follow actions will be taken:

• One staff member will undertake the 3 day Studio 3 training in January 2023.
• PIC as above will continue to review the centres training matrix and ensure that staff attend training in behavioral support in a timely manner.
• Site Specific orientation and induction is provided to all new staff with a list of training requirments to be completed. This has now been reviewed and updated to facilitate all new staff with time during their induction to complete mandatory training on HSEland prior to taking up frontline position.

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 will be taken:
• PIC/CNM2 has reviewed training matrix and has complied a training needs analysis. Each staff member has been furnished with outstanding training needs to be completed by end of January 2023 for all hseland courses with other mandatory training to be completed by March 2023.

• CNM2/PIC has contacted trainers in SASS training to carry out face to face training to be completed by 31/03/2023

• The development of the WIFI policy is ongoing. The Digital Health lead held an information session with the PIC's and identified strategies that are in progress to ensure the use of online equipment safety for Service users.
• Risk assessment for the safe use of Wi-Fi to be developed and completed by 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 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/03/2023
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	31/03/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	28/02/2023

	state of repair externally and internally.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/01/2023
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/01/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/03/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the	Substantially Compliant	Yellow	31/03/2023

	chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/03/2023
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	31/03/2023