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:	Cloghan
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	21 March 2023
Centre ID:	OSV-0008154
Fieldwork ID:	MON-0038764

About the designated centre

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

The centre is located within a small campus setting which contains six other designated centres operated by the provider. Cloghan provides full-time residential care and support to three residents. The designated centre comprises a three bedded single-storey house. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. Residents are supported by a staff team of both nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 21 March 2023	09:40hrs to 17:40hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations since the last inspection of Cloghan on 27 September 2022. This inspection found improvements in the governance and management of the service; however compatibility issues between residents remained which led to some residents feeling unsafe at times. This will be expanded on throughout the report.

Cloghan was one of seven designated centres located on a small campus setting on the outskirts of a town in Co. Donegal. The house could accommodate three residents. One resident was in hospital on the day of inspection and two other residents were in the centre. The inspector got the opportunity to meet with both residents and all staff working on the day.

On arrival to the centre the inspector met with staff, residents and the person in charge. One resident was in the sitting-room watching television and greeted the inspector briefly. They were waiting to go to their day service. On return in the evening, they asked to meet with the inspector again, which was facilitated. Another resident chose to remain in the house during the day and they were observed freely moving around the house and relaxing in their living area. They spoke with the inspector briefly.

Through observations on the day, a review of documentation and discussions with staff, it was found that residents were offered choices about how to spend their day and about what activities they would like to take part in. For example; one resident was observed telling the staff that they didn't want to go out that day and this was respected. There was transport available to support residents to access activities in the wider community if they chose to. Residents had good family contact also and families were found to be involved residents' lives. One resident in particular was reported to enjoy regular visits home to family.

One resident requested to speak with the inspector in the evening. They agreed to show their personal plan, which they went through with the inspector. This included photographs of activities that they enjoyed and goals that they had achieved. When asked, they spoke about their likes and interests and said that they would like to go on a holiday to a particular town. This was followed up by the management team who asked them to discuss this with a named staff member to plan this with them. When asked, this resident said that they did not like living in Cloghan and did not feel safe, and they gestured banging and said they did not like noise from other peers. The resident was reassured by staff supporting them. The local management team were aware of this issue and were involved in reviewing the future living arrangements for residents as part of an overall plan for the campus. This will be discussed further in the quality and safety section of the report.

The house was found to be spacious and homely. Some aspects of the premises required improvements in the maintenance and upkeep. The management team

were aware of this and a plan was in progress to address some of these issues. An application to vary conditions of the service had been submitted in January to change the use of one spare bedroom to a staff office. This was in place and allowed for a space for the local management team to be based.

There was a spacious garden which contained garden furniture, a poly tunnel and putted shrubs. Residents' bedrooms were decorated in line with resident's wishes, with some residents choosing minimal furnishings and some had several framed photographs and furnishings in place. One resident was supported to get a new comfortable chair for their bedroom recently, and they appeared happy when the inspector asked about this. Each resident had access to en-suites or individual bathrooms which had level access showers. One resident was reported to enjoy music and buying records, and they had use of a sitting-room room for their own use.

The house had notices and easy-to-read posters throughout. Residents were consulted and given information about the house through regular residents' meetings. In addition, a visual schedule was in place for one resident and a choice board was used to further support them to make choices about their day-to-day lives. One resident spoke about meals that they liked and said that they were cooking pasta later for their tea. There was a variety of food and drink items stored in the kitchen cupboards and fridge, and each resident had access to their own individual treats which were stored in th kitchen.

Staff spoken with talked about residents' individual needs and preferences and about how choices were made. Staff were observed supporting residents in a caring and responsive manner, and it was evident that residents were familiar with staff and comfortable around them. Staff members spoken with appeared knowledgeable about each resident's likes, interests and the care and support required. Care plans in general were comprehensive; however there were some gaps in documentation. This will be discussed later in the report.

Overall, the inspector found that Cloghan provided person-centred care and support and that staff were familiar with residents' needs. However, due to incompatibility between residents, safeguarding concerns occurred and led to some residents not feeling safe in their home at times.

The next sections of the report describe the governance and management arrangements and about how this impacts on the quality and safety of care and support provided in the designated centre.

Capacity and capability

Overall, the inspector found that Cloghan had a clear governance and management structure with good arrangements in place for oversight. Some improvements were required in risk management documentation, premises and fire safety. In addition,

protection of residents was found not compliant despite the local management and staff's efforts to ensure residents' safety. This will be discussed in the next section of the report.

The person in charge worked full-time and was responsible for one other designated centre. They were supported in the operational management of the centre by a clinical nurse manager 1 (CNM1). The CNM1 worked full-time and also covered another designated centre. They were appointed in January 2023 following a vacancy in his position for the centre since 2022.

The centre was staffed with a skill-mix of nurses and health care assistants. There were three staff supporting residents during day hours and there were two waking night staff each night. There was a consistent staff team working which helped to ensure continuity of care. This was noted as very important for supporting residents with behaviours of concern and to reduce safeguarding concerns. Staff spoken with said that they liked working in Cloghan and that they could raise any concerns to the management team if required. They felt that residents were well cared for and had a good quality of life overall.

There were arrangements for auditing the service and for ensuring ongoing oversight by the management team. An audit schedule was in place which included audits in areas such as personal plans, finances, medication, complaints, fire safety, infection prevention and control (IPC) and health and safety. This also included monthly reviews of incidents that occurred. From a review of incidents, it was found that the person in charge submitted all required notifications to the Chief Inspector of Social Services as required in the regulations.

The provider ensured that unannounced six-monthly visits occurred and that an annual report of the quality and safety of care and support was completed. Both an unannounced visit by the provider and an annual review were due to be completed in the coming weeks. In general, provider audits and local audits were comprehensive and identified actions for improvement.

However, through a review of documentation it was found that there were gaps in some documentation and a number of staff sign off sheets had not been followed up and completed. In addition, staff meetings had not occurred regularly due to the person in charge being on leave towards the latter part of 2022; however a schedule to address this was now in place.

In general, the governance and management of the centre was robust; however some improvements as noted throughout the report were required to achieve full regulatory compliance.

Regulation 15: Staffing

There were the numbers and skill-mix of staff to meet the needs of residents. There was a consistent staff team in place, which included a cohort of regular agency staff

to ensure consistency of care. Staff spoken with said that staffing arrangements were stable and consistent.

A review of the roster found that there were the numbers of staff in place. There was a planned roster in place. However, the actual roster for the current week was not printed off as the person in charge said that this may change; this was addressed this on the day by the person in charge.

Judgment: Compliant

Regulation 23: Governance and management

While the governance and management of the centre had improved and there was now a robust governance structure in place the following issues were found;

- Team meetings did not occur every two months as required. This was reportedly due to the person in charge being on leave for an occasion that it was due to be held and there was not a CNM1 in place at that time. A schedule had since been developed for these meetings to occur, and the person in charge spoke about how they would strive to get the maximum number of staff to attend and participate.
- Some aspects of risk management documentation required review and updating.
- One resident's personal plan did not include a personal goal that they requested relating to their living arrangements for the future.
- Some fire drill records did not provide sufficient detail to provide assurances that all residents could be evacuated to safe locations.
- The documentation relating to the handling of one complaint did not provide sufficient detail about how the complainant was consulted about the outcome, and about what the follow-up actions were that led to the resolution of the complaint.
- Some documentation that required sign off by staff had not been done. For example; behaviour support plans and the local complaints procedures had sign off sheets for staff to sign when read; however not all staff had signed these as read.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of incidents found that all notifications were submitted to the Chief Inspector, as required in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure in place. There was a local complaints procedure developed to guide on the management of complaints in the centre. However, this contained inaccurate information about the appeals process and was not in line with the provider's policy. This was addressed on the day by the person in charge when it was brought to their attention.

There was evidence that complaints were received and managed in accordance with the provider's procedures. However, the documentation regarding a complaint made by one resident was not clear on whether the follow up actions were completed and if the resident was updated on this. This is covered under regulation 23: governance and management.

Judgment: Compliant

Quality and safety

This inspection found that although residents living in Cloghan were provided with care and support that was person-centred; incompatibility of residents remained a concern. This meant that some residents continued to live in an environment that led to them feeling unsafe at times due to the behaviours of others.

There was evidence that safeguarding procedures were followed when concerns occurred and that measures were in place to minimise safeguarding concerns in the centre. The included increased staffing at times when all residents were in the house and environmental strategies. There were ongoing reviews occurring regarding residents' future living arrangements, to include compatibility; however there was no time-frame on when actions to address this would be completed. This was of particular concern for one resident for whom a number of notifications had been submitted to the Chief Inspector since the last inspection in September 2022, and which detailed the impact on them as a result of behaviours directed towards them by others. This resident was facilitated to lodge a complaint about their living arrangement last October which was closed off, and discussions were in progress at management level about compatibility. However, there was no definite plan for the resident to move out, and they told the inspector that they did not feel safe in Cloghan, when asked.

Despite the compatibility concerns that were evident, each resident was found to be supported in accordance with their needs and with appropriate staffing levels that facilitated residents to engage in the individual activities that they chose each day.

Each resident had an assessments of needs completed to assess their health, personal and social care needs. Annual reviews occurred with the participation of residents and their family representatives. Care needs were reviewed and discussed at these meetings. Residents had personal plans in place; however one resident's plan had not been updated with regard to their expressed wishes for alternative living arrangements.

Residents who required support with behaviours of concern had plans in place which included multidisciplinary team (MDT) input. There was evidence that these were kept under review and updated following reviews of incidents that identified possible triggers to behaviours. Restrictive practices that were in place were found to be kept under regular review and discussed with residents.

Residents' general welfare and development was promoted with residents having access to leisure and recreational activities of their choosing. This included activities in the wider community. Residents' rights were promoted through regular meetings where residents were consulted about their day-to-day lives.

There was a risk management policy and procedure, a site specific safety statement and emergency plans in place. The centre had a risk register for service related identified risks. In addition, each resident had assessments where risks were identified. However, there were gaps in some documentation maintained with regard to risk ratings, inaccurate information and non-specific information about a particular risk identified.

There were arrangements and systems in the centre for fire safety. However, one resident's personal emergency evacuation plan (PEEP) did not contain information that staff spoke about, and which was included on a risk assessment as a strategy to support with evacuation. This was followed up and addressed on the day by the person in charge. Although fire drills were occurring, there were some gaps in the documentation which meant that it was not clear that all residents could be evacuated and what the actions, if any, that were required to be followed up.

In summary, this inspection found that residents were supported with their assessed needs in a person-centred manner. However, due to the incompatibility of residents this meant that some residents did not feel safe at times in their home and there was no clear time bound action identified to address this.

Regulation 13: General welfare and development

Residents were supported to engage in activities that were of interest to them both in the house and in the wider community. Residents had opportunities for leisure and recreation in the house such as baking, access to a SMART television, music players, technological devices and gardening.

One resident attended a day service each day and could choose to remain at home if they wished to also. One resident chose not to attend external day services, and

they were supported to do activities from the house. Another resident was linked in to community groups and could choose to participate in these if they so wished.

Judgment: Compliant

Regulation 17: Premises

The premises was spacious to meet the numbers and needs of residents. Each resident had their own bedroom and access to individual bathrooms. There were two spacious sitting-rooms which supported residents to have private space if they so wished.

However, some aspects of the maintenance and upkeep of the premises required completion. These issues had been identified by the management team and there were plans for these issues to be addressed. They were;

- Replacement of some fire doors.
- Replacement of flooring in some rooms and in the hallway.
- Some internal walls required painting as they were visibly marked.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There was a risk management policy and procedure in place. The service had a risk register which included risks identified for the service. In addition, each resident had risks assessments and nursing interventions in place for any identified risks. The following was found in relation to aspects of the risk management documentation;

- One resident's risk assessment documentation had gaps in information such as missing risk ratings, inaccurate information about the name of the centre and some parts were not clear on what the actual risks were that had been identified to inform the control measures.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were arrangements in place for fire safety management such as fire safety checks, fire containment measures, a fire alert system and fire extinguishers. Some fire doors had wear and tear and these had been identified, assessed by a fire

specialist and were due to be replaced in the coming weeks. This is covered under Regulation 17: premises.

Fire drills took place and each resident had a personal emergency evacuation plan (PEEP) in place. However, the following was found:

- One resident who was noted to refuse to participate in fire drills at times had a PEEP in place that did not include measures that staff spoke about using to support the resident to leave the building. This PEEP document was updated on the day by the person in charge.
- Some fire drill records indicated that one resident refused to evacuate during some fire drills. On a further fire drill that occurred this year, it was not clear on the record if this resident had left the building or not. While the inspector was informed that this was a successful fire drill and that an action had been identified as a result and was in progress, the record did not reflect this.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had assessments completed on their health, personal and social care needs. There were a range of personal care plans and interventions in place to support with assessed needs. Residents and their family representatives participated in annual review meetings where residents' care and support were discussed.

However, the following was found in relation to one resident's personal plan;

- While actions were in progress to review one resident's living arrangements as part of an overall plan for the campus, the resident's personal plan did not include their expressed wishes to move to an alternative home.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to achieve good health and wellbeing. Where required residents were facilitated to access allied healthcare appointments, national screening programmes and vaccine programmes. Residents had regular access to a general practitioner (GP) as, and when, needed. The GP was visiting one resident in the centre on the day of inspection. Residents were supported to discuss end-of-life arrangements and to develop a plan, as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff received training in behaviour management. Residents who required supports with behaviours of concern had comprehensive positive behaviour support plans which were found to be up to date and included input from relevant multidisciplinary team (MDT) members.

Restrictive practices were found to be clearly assessed, documented and kept under ongoing review. Restrictive practices affecting residents were found to be discussed and reviewed at residents' annual review meetings, which demonstrated ongoing consultation with residents about decisions affecting their care.

Judgment: Compliant

Regulation 8: Protection

Staff had received training in safeguarding and there were policies and procedures in place for the management of concerns. Where safeguarding concerns occurred, these were found to be followed up in line with the procedures and safeguarding plans were developed where required. Staff spoken with were aware of measures to reduce safeguarding concerns between residents. Compatibility between residents was regularly reviewed and discussed at management meetings about de-congregation. However, the following was found;

- Incompatibility between residents was an issue in Cloghan. This was noted and reflected in notifications to the Chief Inspector, in behaviour support plans and in safeguarding documentation. When asked, one resident spoken with said they that did not like living in Cloghan and that they did not feel safe due to the noise and banging. This was acknowledged by the management team and was under ongoing review; however there was no time-frame about when the resident could move to an alternative accommodation in which they would feel safe. This was of concern as the incompatibility issues were longstanding and there remained no definite plan to support the residents affected to live in a home that they felt safe in.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were consulted and supported to make every day choices in their lives. This included; choices about their religious preferences, choices about going to a day service or community group, choices about shopping. While there remained a central kitchen from which two main meals were offered and delivered each day, residents were offered choices about these means and they also had the option to cook in their home.

Staff were supported to undertake Human Rights training, and this was part of the provider's identified training. Staff spoken with talked about how residents made choices in their lives and how their individual life choices were respected. Residents were supported to avail of independent advocacy services and this was noted to be in place for some residents.

The provider had a Human Rights Committee in place which had held a number of meetings over 2022 and 2023. This was reported to still be at a planning stage regarding how the reviews of residents' individual rights would occur. The development of this committee demonstrated a commitment by the provider to implement and further develop a rights-based approach to service provision.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cloghan OSV-0008154

Inspection ID: MON-0038764

Date of inspection: 21/03/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

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

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

1. The Person in Charge has developed a schedule for bi monthly governance meetings for 2023. All staff will be invited to attend each meeting according to the schedule to provide the opportunity to discuss all matters relevant to the centre and their role. The minutes from each governance meeting will be available in the centre for all staff to read and sign off. In the absence of the Person in Charge, the CNM1 will facilitate any scheduled meetings. Date completed April 18th 2023.

2. The Person in Charge has completed a review of all risk assessments in the centre and all risk assessments have been updated to ensure that all information is accurate and reflective of the appropriate risk rating. Date completed on 30th March 2023.

3. The Named Nurse has reviewed and updated the personal plan for one resident to include a personal goal for future accommodation arrangements. Date completed 3rd May 2023

4. The Person in Charge and the CNM1 has completed a fire drill in conjunction with staff working in the centre to ensure that all fire drill records provide all information pertaining to the drill to ensure the safe evacuation of each resident. Date completed May 9th 2023

5. The Person in Charge has reviewed all documentation in relation to complaints with particular reference to the complainant being happy with the outcome. The Person In Charge will ensure that all complaints received will be managed in accordance with the Complaints procedure. Date completed 30th March 2023.

6. The Person in Charge and CNM1 has completed an audit of all sign off documents Date completed May 8th 2023.

7. The Person in Charge will ensure that staff sign off on any documentation that is required i.e. Positive Behaviour support plans, policies. Date for completion May 31 2023.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The Person in Charge in liaison with the Maintenance department have developed a schedule to complete the replacement of fire doors. This process has commenced and it is anticipated that the work will be completed by July 31st 2023. Date for completion 31 July 2023
2. Flooring has been replaced in the sitting room and hallway as planned. Date completed on April 5th 2023.
The Person in Charge in liaison with the Maintenance department are sourcing quotations for painting of the house. This process will commence as soon as a date is agreed with the identified contractor. Date for completion 31 July 202

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The Person in Charge has completed a review of all risk assessments in the centre and all risk assessments have been updated to ensure that all information is accurate and reflective of the appropriate risk rating. Date completed 30th March 2023.

2. The Person in Charge will review all risk assessments and associated documentation on a quarterly basis or sooner if required. Date completed 30th March 2023

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The Person in Charge and the CNM1 has completed a fire drill in conjunction with staff working in the centre to ensure that all fire drill records provide all information pertaining to the drill to ensure the safe evacuation of each resident. Date completed May 9th 2023

2. The Person in Charge and the CNM1 will continue to review all PEEPS following fire drills to ensure that all information is available for staff to support each resident in the safe evacuation during drill. Date completed May 9th 2023 and ongoing

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. The Named Nurse has updated the core nursing assessment to reflect the will and preference of one resident regarding future living arrangements. Date completed May 3rd 2023

2. The Named Nurse in conjunction with the resident has put in place a goal for future living arrangements. Date completed May 3rd 2023

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Person in Charge will continue to respond to any safeguarding concerns as they arise within the centre.

2. The Person in Charge, CNM1 and staff team in conjunction with staff member who completed Enhanced, Quality and Transiton programme(EQT) has commenced work with one resident to establish their will & preference in relation to future living arrangements This work be completed in all areas of the resident's life(day service, social activities) Date completed February 28 2023 and ongoing.

3. This centre is included in the overall decongregation plan for Ard Greine Court campus and there is a schedule of monthly compatibility and decongregation meetings to progress this process. Date completed 5 May 2023 and ongoing

4. The Person in Charge and CNM1 in conjunction with the staff team & MDT will continue to progress compatibility for all residents. Meetings regarding compatibility are held on a monthly basis and a representative from the centre attends all meetings. Date for completion May 11th 2023 and ongoing.

5. The Person in Charge in liaison with the MDT will continue to prioritise one particular resident in sourcing alternative accommodation suitable to meet the needs and preferences of the resident. Date for completion 31 October 2023

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/07/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/05/2023
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to	Substantially Compliant	Yellow	31/05/2023

	raise concerns about the quality and safety of the care and support provided to residents.			
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	30/03/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/07/2023
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	03/05/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2023