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:	Inbhear Na Mara
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	15 November 2022
Centre ID:	OSV-0002496
Fieldwork ID:	MON-0036897

About the designated centre

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

Inbhear Na Mara provides accommodation for 10 adults over the age of 18 years with an Intellectual disability who have high support and complex needs in terms of their physical and medical needs. The unit was purpose built to accommodate persons with complex needs and all accommodation is at ground level and is suitable for wheelchair users or people with limited mobility. All bedrooms are single occupancy and some have direct access to the garden areas via double doors. Residents have access to a range of communal seating areas, a dining room and quiet room where residents can spend time alone if they wish. In addition to shared toilet and bathing facilities a number of residents have en suite shower and toilet facilities. The centre is located in a small town and is staffed 24 hours with nurses on duty at all times.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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	09:30hrs to 15:30hrs	Úna McDermott	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. This included a targeted inspection programme which took place over two weeks in January 2022 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection) and regulation 23 (Governance and management). The overview report of this review has been published on the Health Information and Quality Authority (HIQA) website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Donegal.

At the time of inspection, the provider had started to implement a number of actions to strengthen the governance and management arrangements in this designated centre. These will be discussed later in this report.

This centre was a congregated setting and institutional in design, however improvements in the premises had been made since a previous inspection. Inbhear na Mara was a large single-story building which provided level access for residents with physical disabilities. The facilities provided included residents' sleeping quarters, all of which had facilities for bathing and showering close by. There was a large dining room and a kitchen where a professional catering service was provided. There was a smaller kitchenette provided in the residents' living area which had facilities for the preparation of hot drinks and snacks. In addition to this, a space for residents to prepare light meals was provided to the side of the activity room. These facilities could be used when the main kitchen was closed. Towards the front of the building there was a spacious sitting area, where residents could watch TV, listen to music or participate in activities. A multi-sensory room was provided for residents that wished to spend time relaxing alone or in small groups. Although the centre was institutional in presentation, the inspector saw that efforts were made to ensure that the environment was as homely as possible. For example; arts and crafts were on display, along with newspapers, family pictures and greeting cards. This was an action from a previous inspection in June 2020 which included the requirement for improvement of the premises. This will be expanded on below.

On the morning of inspection, the inspector met with three residents who were sitting near the entrance. They did not communicate with the inspector however, the staff on duty carried out introductions and explained that two residents were waiting for transport to take them to their day service along with three other residents. This meant that four residents remained at the designated centre where a

programme of structured activity was provided.

The inspector observed one resident who was relaxing in the sitting room watching a farming programme on television which they appeared to enjoy. A second resident spoke with the inspector briefly about a planned trip home which they appeared to be looking forward to. Later, the inspector met with a resident who was walking towards the dining room. This resident required the support of two staff members at that time. The inspector spent some time in the dining room during breakfast and observed three residents sitting at separate tables. This was reported to be for social distancing reasons. A menu plan was provided with two choices for both lunch and dinner. This was available in easy-to-read picture format for residents' use and was an accurate reflection of what was on the menu for that day. Residents that required support with eating and drinking had this provided and a folder with speech and language therapy recommendations was available to guide staff if needed.

Later that morning, the inspector observed residents enjoying a music therapy session which was taking place in a communal area. Residents were observed making choices about the songs and singing when they were played. The staff on duty told the inspector that a range of interactive sessions were provided each week which were enjoyed by residents that remained at the centre for the day. These included art sessions and reflexology.

The person in charge told the inspector that residents were supported to have contact with their families and their community. This included visits home, family visits to the designated centre and overnight stays for some residents during holiday times.

It was evident to the inspector, that the residents at Inbhear na Mara had high support needs. These included physical and sensory disabilities and medical conditions that were increasing as the residents aged. As previously outlined, some residents required the support of two staff in order to protect them from risk and to keep them safe. On the day of inspection, there was one staff nurse on duty who was employed by an agency. Support was also provided by healthcare assistants, and on the day of inspection, one healthcare assistant was also employed by an agency. All staff were observed to be knowledgeable of the residents' needs and were respectful when speaking with them. However, due to the high support needs of the residents, the inspector found that the skill mix and consistency of staff provided required improvement and this will be expanded on below.

The next two sections present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to the resident.

Capacity and capability

This inspection was a follow up to the targeted inspection programme that took place in CHO1 in January 2022. A follow up to the compliance plan of the overview reported was submitted to the Chief Inspector of Social Service in July 2022. During the course of this inspection, it was noted that most actions had been completed, or were in the process of being completed. However, further improvements were required with the statement of purpose, the systems in place to provide adequate staffing and training, the processes used to support positive behaviour and manage risk, and the overall governance management and oversight of the designated centre.

The management structure in this designated centre consisted of a person in charge who reported to the area co-ordinator. However, recently the person in charge vacated their post and the area co-ordinator now acted as person in charge, along with their substantive managerial post. On the day of inspection, a person in charge from another designated centre, but who was very familiar with Inbhear na Mara was available on site to support their colleague with the inspection process. As part of the inspection, the inspector reviewed the statement of purpose for the designated centre and found that due to the recent changes outlined above, that the organisational structure and governance arrangements required review and updating. A plan was in place for this to be actioned.

Staffing arrangements were reviewed as part of the inspection. The skill mix included nursing staff and healthcare assistants. There was a planned and actual staff roster in place which showed that there was an adequate number of staff working to meet with the residents assessed needs. However, the inspector found that the provider failed to provide an adequate skill mix in order to meet with the residents assessed needs. This was due to the fact that some residents had clinical care needs that, at the time of inspection, required the support of nursing staff. For example, one resident had epilepsy and was prescribed emergency medication if required. The inspector found that on one occasion they were unable to attend an activity of their choice as there was one staff nurse on duty who was unable to leave the designated centre. On another occasion, the resident spoke with staff about not getting out as often as they wished. The inspector reviewed a sample of the rosters provided and found that on five occasions over the previous five weeks there was one nurse on duty. On other occasions, the person in charge, who also acted as area co-ordinator was required to provide nurse cover. In addition, staff nurse cover was raised as a concern by the staff members spoken with who told the inspector that they would like to do more with the residents if they had the capacity to do so. This meant that although the provider had a recruitment campaign in place, it was evident that the service operated at a level below the core skill mix requirements at times and this impacted on the lived experiences of the residents.

A review of training records in the centre showed that staff training was provided as part of a continuous professional development programme. Staff spoken with told the inspector that they had access to training as required and furthermore, there was a programme of formal supervision for staff in place. The person in charge told the inspector that a staff training matrix was recently introduced and details of staff training were logged. A sample of training records reviewed demonstrated that in

general, staff members had competed the mandatory and refresher training as required. However, the inspector found that although agency staff members were frequently used in this centre, not all their training records were available for review. For example, two agency staff did not have training records for positive behaviour support or fire training available for review and one had no training record for safeguarding and protections training available. This system required updating.

During this inspection, actions relating to the providers commitment to strengthen the governance and management systems in place in its Donegal services were reviewed and all were found to be completed or progressing. The person in charge told the inspector that they attended the county and network area meetings as required and that they facilitated the service level meetings locally. These were reported as productive, interesting and that they provided an opportunity for shared learning. At service level, there was a schedule for staff governance meetings in place and a sample of minutes were reviewed. Agenda items included discussions on matters relating to residents care, person centred plans, audit and inspections. At times, not all staff were available to attend. However, there was evidence that the minutes were read and signed by staff at a later stage.

The provider-led unannounced six monthly audit was completed in May 2022. It identified a number of areas for improvement and actions were prioritised. These included the fact that agency staff were used regularly in the designated centre and that nursing posts were vacant. The annual review of care and support took place in November 2021 and although due for review in the near future, was up-to-date on the day of inspection. The provider had introduced a new audit schedule recently and corresponding audits were reviewed by the inspector. The inspector found that these were monitored and updated by a named staff member who at the time of inspection had the capacity to assist the person in charge with this role. The audit schedule was clearly displayed and audits were completed on complaints and restrictive practices (quarterly), incidents and safeguarding (monthly) and in addition, there were a number of weekly and daily audits in place.

The centre had a quality improvement plan (QIP) which contained actions arising from the provider audits, inspections by the Health Information and Quality Authority (HIQA) and a self-assessment audits completed by the person in charge. The inspector reviewed the most recent QIP and found that actions were recorded in relation to staff nurse vacancies at the designated centre and the requirement to fill these vacancies. This action was ongoing.

A complaints procedure for residents was available and was reviewed by the inspector. The policy on the management of complaints was up-to-date and local guidelines to support staff were in place. Information on submission of complaints was displayed on the residents' notice board and a picture of the complaints officer was provided. The inspector found that residents were supported to understand the complaints process as it was a standing agenda item for the weekly residents' meetings held. Furthermore, where residents had a concern they were supported to document this.

The inspector reviewed the incident management system used in the centre and

found that it was used appropriately to report concerns. Monitoring notifications were reported to the Chief Inspector in a timely manner and in accordance with the requirements of the regulation.

The next section of this report will describe the care and support that people receive and if it was of good quality and ensured that people were safe.

Regulation 15: Staffing

The registered provider failed to ensure that the number and skill mix of staff was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre. This was due to the fact that some residents had clinical care needs that, at the time of inspection, required the support of nursing staff. For example, one resident had epilepsy and was prescribed emergency medication if required. The inspector found that on one occasion they were unable to attend an activity of their choice as there was one staff nurse on duty who was unable to leave the designated centre. A sample of rosters reviewed showed that on five occasions over the previous five weeks there was one nurse on duty. On other occasions, the person in charge, who also acted as area co-ordinator was required to provide nurse cover. In addition, staff nurse cover was raised as a concern by the staff members spoken with who told the inspector that they would like to do more with the residents if they had the capacity to do so.

This meant that although the provider had a recruitment campaign in place, it was evident that the service operated at a level below the core skill mix requirements at times and this impacted on the lived experiences of the residents

Judgment: Not compliant

Regulation 16: Training and staff development

Access to appropriate training, including refresher training was provided as part of a continuous professional development programme. A staff training matrix was in place. However, improvements were required in the following areas;

- to ensure that all training modules for all staff were up to date and available for review

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangement at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO 1.

At the time of inspection, the person in charge spoke with the inspector about 11 of the actions that had commenced. Seven of these related to setting up of committees and meetings that had commenced. For example, at county level the person in charge meetings were ongoing. The policy, procedure, protocol and guidelines development group meetings had commenced and the person in charge attended and was aware of the work being completed. At network level, the governance for quality safety service improvement meetings were ongoing along with the safeguarding review meetings which were taking place. At centre level, the person in charge and the disability manager met regularly and staff governance meetings in the centre were occurring in line with the provider's compliance plan.

In general, although there was a management structure in place in the designated centre, the inspector found gaps in the provider's ability to fill the post of person in charge which was recently vacated. Furthermore, there was a requirement for effective oversight of the staffing arrangements in place in order to ensure that they met with the assessed needs of the residents. This required improvement in order to ensure that sufficient, consistent, experienced and trained staff were available in order to meet with residents requests and to provide a quality and safe service at all times.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which was subject to regular review. However, it was not in line with the requirements of Schedule 1 of the regulations and improvement was required in the following area;

- to ensure that the management, staffing and organisational structure of the service is an accurate reflection of the service provided.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured that monitoring notifications were reported to the Chief Inspector in a timely manner and in accordance with the requirements of the regulation.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had an effective complaints procedure in place which was accessible, age appropriate and prominently displayed. Residents were assisted to understand the complaints process and a record of complaints was held at the centre.

Judgment: Compliant

Quality and safety

Residents living at Inbhear na Mara were provided with a good level of care and support and the efforts made to improve their home environment were evident. However, further improvements were required with the statement of purpose, the systems in place to provide adequate staffing and training, the processes used to support positive behaviour and manage risk, and the overall governance management and oversight of the designated centre.

The inspector reviewed a sample of residents' care plans and person-centred plans. The review found that annual reviews were taking place, that they were person-centred and where possible residents' families were involved in this process. Each resident had a named nurse and there was evidence of goals agreed and pursued. For example, one resident wanted to purchase a tent and a swing for outdoor use during the summer. The inspector noticed the tent in the sun room and the staff on duty told the inspector that the swing was in place. Residents had access to the services of a general practitioner and to allied health professionals if required. This included the support of a speech and language therapist as previously outlined. The inspector reviewed the recommendations of swallowing assessments completed and found that they were up-to-date and available to guide staff if required. In addition, the support of the occupational therapist was provided in order to provide a resident with an adapted bed and access to physiotherapy, audiology and mental health services was provided if required.

Residents that required support with behaviours of concern had positive behaviour support plans in place. These were reviewed and updated regularly and there was evidence of the involvement of allied health professionals such as the psychologist in

this process. In some cases, the person in charge told the inspector that the support of positive behaviour was managed through nursing care plans. This meant that there were two pathways for behaviour support provided. This approach was not always consistent and required review. Restrictive practices were in use in this centre and there was a site specific protocol in place which was reviewed in August 2022. Furthermore, a restrictive practice log was in use and this was reviewed quarterly. However, the inspector found that due to difficulties with staff recruitment and as discussed previously, it was unclear if the agency staff on duty had completed training in positive behaviour support. This required review.

The provider had ensured that measures were in place to ensure that residents were safeguarding and protected from abuse. For example, the person in charge acted as designated officer and their picture was prominently displayed on the notice board. Furthermore, staff spoken with were aware of who the designated officers was and of what to do if a compliant arose. Residents requiring support with personal care had intimate care plans completed. Where a concern arose, this was followed up on promptly by the person in charge and in line with safeguarding procedures. Safeguarding plans were developed as required. Safeguarding was a standing agenda item on the staff governance meetings which were held in the centre. The majority of staff had completed training in safeguarding and protection. However, the training records in relation to one agency staff member were not available on the day of inspection. In relation to the provider's compliance plan submitted, one action required further attention. These was the requirement to attend sexuality awareness training which was yet to be provided for all staff. In relation to the provision of a policy on safe wifi provision, this matter had an extension to the original timeframe which had been agreed with the provider. This meant that it was not due for completion until the end of January 2023 and therefore was not outstanding.

The provider had risk management systems in place which included a policy and procedure for risk management in the centre. A risk register was maintained and where risks were required to be escalated to senior management, this had been done. Core risks for the centre were identified and residents had individual risk assessments completed if required. However, some improvements were required as the site specific safety statement which outlined emergency plans for the centre was for another designated centre and not for Inbhear na Mara. This required review.

The provider ensured that there were systems in place for the prevention and control of infection and it was evident that the centre was clean and tidy. Systems included staff training, posters on display around the centre about prevent infection transmission, use of personal protective equipment (PPE) and availability of hand sanitisers. In addition, there were systems in place for the prevention and management of the risks associated with COVID-19; including up-to-date outbreak management plans, risk assessments and ongoing discussion with staff about the risks of COVID-19. The COVID-19 policy statement was up-to-date and a named lead worker representative was identified. The IPC self-assessment tool was completed.

As previously stated this designated centre was institutional in design and concerns

regarding the premised were identified during a previous inspection in June 2020. A walk around of the centre found that the provider had completed the actions that they committed to as part of their compliance plan at that time. These actions included the painting and decoration of residents' bedrooms in line with their preference and the personalisation of the living areas throughout the centre. Furthermore, the kitchen facilities were upgraded and a kettle, toaster, microwave and small hob were provided for residents use. A range of drinks and snacks were available for times when the main kitchen area was closed. In general, although institutional, it was evident that staff made every effort to ensure the environment provided was as homely as possible.

Regulation 17: Premises

The provider ensured that the premises provided was clean, suitably decorated and in a good state of repair.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had risk management systems in place which included a policy and procedure for risk management and a site specific safety statement which outlined emergency plans for the centre. However, improvements were required in the following areas;

- to ensure that the site specific safety statement was relevant to the designated centre

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider ensured that there were systems in place for the prevention and control of infection including the management of risks associated with COVID-19.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that residents had an annual assessment of their health, personal and social care needs. These were person centred and included consultation with family members where appropriate.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a medical practitioner and to allied health professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements in relation to positive behavioural support. One action related to multi-disciplinary supports, three actions related to staff training and in ensuring staff had adequate knowledge about behaviour support plans and three actions related to the induction of new staff.

On the day of inspection, the person in charge told the inspector that all seven actions were provided for at Inbhear na Mara. For example, there was evidence that staff were required to read and sign residents' positive behaviour support plans. In addition, the new training matrix was in place and training needs were discussed at person in charge meetings at centre level and at county level.

On this inspection, the inspector found that residents that required support with behaviours of concern has positive behaviour support plans in place. However, the following areas required improvement;

- to ensure that there was a consistent approach to the provision of positive behaviour support plans
- to ensure that all staff had up-to-date training in positive behaviour support and the evidence was available for review

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements in relation to safeguarding and protection.

A safeguarding tracker log was to be introduced for each network area by the end of March 2022. At the time of this inspection, the safeguarding tracking log was in use and the additional weekly cross referencing of incidents had commenced. Training on preliminary screening of safeguarding concerns was provided and reported to be very helpful. Of the 13 actions proposed by the provider, there was evidence of 12 actions completed or in progress. The training on Sexuality Awareness was not provided for all staff. However, a plan was in place to progress this.

On this inspection, the inspector found that there were arrangements in the centre for safeguarding. The provider had a safeguarding policy in place and this was up-to-date and reviewed regularly. Where a concern arose, this was followed up on promptly by the person in charge and in line with safeguarding procedures and safeguarding plans were developed as required. However, the following area required improvement;

- to ensure that all staff had up-to-date training in safeguarding and protection and the evidence was available for review

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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Inbhear Na Mara OSV-0002496

Inspection ID: MON-0036897

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to bring this centre into compliance the following actions have or will be taken: • A review of the current skill mix will be undertaken to ensure the most appropriate skill mix is agreed upon to best meet the needs of residents. This will be completed by 30/12/2022. • A programme of recruitment is ongoing in relation to the filling of vacant staff nurse positions in this centre. 31/03/2023. In the interim these nursing positions will be replaced on a temporary capacity by use of overtime and regular agency nursing staff.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In order to bring this centre into compliance the following actions have or will be taken: • The person in charge has contacted the staffing agencies and has requested a list of all relevant training completed along with certificates confirming same. These will be stored in the centre and made available for Inspection. • A review of training requirements of agency staff has been completed and the Person in charge is arranging relevant training for these Individuals. • All outstanding training will be completed by 17/02/2023.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In order to bring this centre into compliance the following action will be taken:

• A Clinical Nurse Manager will be appointed to this centre to strengthen the governance and to ensure that appropriate staffing arrangements are in place to meet the assessed needs of the residents. 31/03/2023. In the interim the Area Coordinator will continue to provide governance to this centre.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
In order to bring this centre into compliance the following action has been completed:

• The Centres Statement of Purpose has been reviewed and updated in relation to the management, staffing and organizational structure of the service. This was completed 23.11.2022.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to bring this centre into compliance the following actions have been completed:

• The centres site specific safety statement has been reviewed and updated. This was completed 15.11.2022

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In order to bring this centre into compliance the following actions have/are been completed.

• Behaviour support plans have been transferred from nursing care plans to the correct behaviour support template. This will be used consistently within the centre going forward. 30/11/2022
• The person in charge has contacted the staffing agencies and has requested a list of all relevant training completed along with certificates confirming same. These will be stored in the centre and made available for Inspection. 17/02/2023
• A review of training requirements of agency staff has been completed and the Person in charge is arranging relevant training for these Individuals. All outstanding training will be completed by 17/02/2023.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In order to bring this centre into compliance the following actions will/have been completed:

• The person in charge has contacted the staffing agencies and has requested a list of all relevant training completed along with certificates confirming same. These will be stored in the centre and made available for Inspection.
• A review of training requirements of agency staff has been completed and the Person in charge is arranging relevant training for these Individuals
• All outstanding training will be completed by 17/02/2023.
• All staff working in the centre will have sexuality awareness completed by January 31/01/2023.

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 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	31/03/2023
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	31/03/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	17/02/2023

	as part of a continuous professional development programme.			
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(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	31/03/2023
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	15/11/2022
Regulation 03(1)	The registered	Substantially	Yellow	23/11/2022

	provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Compliant		
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	17/02/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	17/02/2023