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:	Sliabh Glas
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	24 May 2022 and 25 May 2022
Centre ID:	OSV-0002518
Fieldwork ID:	MON-0031145

About the designated centre

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

Sliabh Glas is a designated centre run by the Health Service Executive (HSE) in Community Healthcare Organisation 1 (CHO1). Sliabh Glas provides a full-time residential service, with 24 hour support, to six adults with an intellectual disability. The centre comprises a dormer style bungalow and separate annex, and is located on the outskirts of a large town. The centre has access to it's own bus to facilitate community based outings and activities. Each resident has their own bedroom. Within the main house residents share communal areas which include the kitchen, utility room and sitting-room. Residents also have access to two bathrooms, one with a bath and one with a walk-in shower. The separate annex flat provides accommodation for one resident, and has an open plan kitchen and living area as well as two bedrooms and a shared bathroom. Residents also have access to a mature, private garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 24 May 2022	14:10hrs to 18:20hrs	Angela McCormack	Lead
Wednesday 25 May 2022	09:30hrs to 14:00hrs	Angela McCormack	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 Donegal. 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 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 the inspection, the provider had started to implement a number of actions to strengthen the governance and management arrangements. These will be discussed in the other sections of the report.

Sliabh Glas consisted of a two-storey detached house and a self-contained flat. There were six residents living in Sliabh Glas at the time of inspection. Five residents lived together in the main house, and one resident had their own self-contained flat. The inspector got the opportunity to meet with all residents over the course of the inspection and residents interacted with the inspector on their own terms.

Some residents were at home from their day services at the time of inspection due to in-house training for staff at their day service. On arrival to the centre, the inspector met with one resident and a staff member who were going for a walk around the grounds of the centre. The resident greeted the inspector and later spent some time talking with the inspector in the sitting-room. Residents were observed to be relaxing or freely moving around their home and appeared comfortable in their environment and with staff.

Residents spoken with said that they liked living in the centre and that they felt safe. One resident spoke to the inspector about topics of interest to them, such as football, and they were observed having a jovial conversation with the staff on duty about football teams. The inspector was informed that most residents enjoyed football and some residents supported different teams. One resident's bedroom was observed to be decorated with their preferred football team’s colours.

Some residents spoke about the house meetings that occurred in the centre. When asked, one resident said that they would go to the 'designated officer' if they had any concerns about their safety. It was observed that there were notices and easy-

to-read posters on display throughout the centre about who the designated officers were and about how to contact the confidential recipient. Another resident told the inspector that they would go to staff if they had any concerns, and they said that staff would listen to them.

Throughout the inspection, residents were observed doing various activities and household tasks. There was a bus available for the centre which supported residents to access community-based activities in line with their choices. One resident spoke about their plans to go shopping and run personal errands with staff during the day, and another resident got a delivery of a new piece of furniture that they had ordered.

Staff were observed to be supporting residents in a caring and respectful manner. There was a warm and friendly atmosphere in the house. Interactions observed between residents and staff were respectful and engaging. Throughout the inspection, residents were observed listening to, and enjoying music with support staff and watching football games on the television. Some residents were observed relaxing in their bedrooms watching television. The inspector met briefly with one resident who lived alone. They were observed having a meal and they appeared relaxed in their home and with staff supporting them. They were reported to be going out for a drive on the bus and a walk later that day.

The premises were homely, clean and personalised with photographs and soft furnishings. The bedrooms that the inspector observed were noted to be personalised and decorated in line with residents' wishes and interests. There were potted plants observed around the house and the garden contained raised planting beds and garden furniture for residents to sit out and enjoy. The person in charge said that there were plans to develop an external 'man shed' for residents to use for leisure purposes. One resident spoke about gardening and a plant stand that they had made, which was observed out in the back garden area.

From discussions with residents, staff and a review of documentation it was found that residents enjoyed a range of activities in their home and in the community. These included; going on home visits, receiving visitors, going to the cinema, attending Mass, going to music concerts and having meals out. Residents were supported to identify personal goals that they would like to achieve. Some goals included; getting artwork done in their home, going to football matches, going swimming, going bowling and going for a Jacuzzi. Goals were noted to be under ongoing review.

In general, the inspector found that the service strived to provide a quality, safe and person-centred service to residents. However, fire safety arrangements required improvements and on the day of inspection an urgent action was issued to the provider to address urgent fire risks in the self-contained flat. This will be discussed in more detail in the 'quality and safety' section of the report.

The following sections of the report outline the governance and management arrangements and how this impacts on the quality and safety of care provided to residents.

Capacity and capability

This inspection was carried out to monitor compliance with the regulations and to review the provider's actions from the targeted inspections completed in January 2022. The inspector found that there was a good organisational structure in place with clear lines of accountability and that there were arrangements in place for monitoring and auditing the centre. However, improvements were found to be required in a number of areas such as; staffing, staff training, residents' rights, the implementation of the provider's actions for the ongoing protection of residents and some aspects of risk management. In addition, fire risks were found on the day of inspection and the provider was issued with an urgent compliance plan to address these risks.

The person in charge worked full-time and was responsible for one other designated centre in the county. While they were on leave at the time of the inspection, they made themselves available at times during the inspection. They informed the inspector about actions that had been implemented as part of the provider's action plan from the overview report. It was reported that all committees and meetings to strengthen governance that were outlined under regulation 23 were implemented. Minutes of some of these meetings were not reviewed at the time of inspection, however the inspector was verbally assured that progress was made in implementing all 11 actions under this regulation.

The person in charge maintained a folder with minutes of county level management meetings and individual meetings with the director of nursing (DON). A review of these meetings demonstrated that learning from other persons in charge in the county were shared. In addition, the person in charge reported that they met with the DON to review centre-specific issues. Minutes of these meetings demonstrated that a comprehensive review of the centre took place where actions for improvement were identified. The person in charge had developed a schedule for the centre team meetings which ensured that a bi-monthly meeting was planned, as outlined in the overview report.

The staffing arrangements in the centre were reviewed as part of the inspection. The skill-mix detailed in the statement of purpose (SOP) included nursing staff and healthcare assistants. The resident living in the flat was supported on a 1:1 basis and staff covered a sleepover shift there each night. In the main house, residents were supported with up to three staff at times during the day, with one waking night and one sleepover staff providing cover each night. There was a planned and actual rota in place which showed that there were the numbers of staff on duty to support residents. However, due to various long-term staff absences, the nursing requirement of two whole-time-equivalent (WTE) as outlined in the SOP, was not in place. This had also been included in an escalated risk completed by the person in charge regarding the changing needs of one resident. The inspector was informed that recruitment for a staff nurse was in progress. The completion of this

recruitment would ensure that the numbers of staff nurses would be in line with the SOP to meet the assessed needs of residents. In the meantime, the person in charge spoke about arrangements to minimise risks, such as reviewing the staff nurse's shift patterns, and the person in charge made themselves available at times for nurse-related duties.

Staff training and development was reviewed. The provider had a list of mandatory training that staff were required to complete as part of their continuous professional development. The training records maintained by the person in charge included all staff working in the centre, including regular agency staff. However, it was found that there were gaps in the completion of some mandatory and refresher training programmes. This included the practical aspect of manual handling training for one staff, refresher safeguarding, hand hygiene and the use of personal protective equipment (PPE) for one staff, behaviour management for two regular agency staff and supporting sexuality in supported settings (SASS) for seven staff. In addition, as part of the provider's action plan for the overview report, each area was to complete a training needs analysis and develop a schedule to meet the training requirements for 2022. The inspector asked to review this and the person in charge presented a document called 'Annual training plan 2022', which outlined the names of staff in the centre who were overdue for training. The person in charge had further completed their own review of this and had taken actions to try to address gaps in a timely manner; such as giving staff a time frame in which to complete online mandatory training.

The provider had completed the unannounced provider six monthly audits and an annual review of the quality of the safety and care provided in the centre, as required in the regulations. This included consultation with residents and their advocates. However, the documentation of this consultation required review to ensure that there was no information included that could personally identify a resident or their representative, and their personal information.

A review of incidents and practices in the centre indicated that the person in charge had submitted all notifications as required in the regulations to the Chief Inspector. The person in charge had a schedule in place for a range of local audits to be completed in the centre. This demonstrated that there were arrangements for ongoing oversight and monitoring of the centre by the local management team. These included audits in medication, health and safety, restrictive practices, personal plans and fire safety. However, the provider and local audits required improvements as they failed to identify fire safety risks that were evident on inspection, including that the regular checks for fire safety were ineffective in appropriately reviewing arrangements in one part of the centre.

Overall, the inspector found that there were systems in place for the ongoing monitoring and oversight of the centre by the management team. However, these required improvements to ensure that all risks were appropriately identified and responded to. In addition, the completion of staff recruitment to ensure that the staff skill-mix was in line with the SOP and the completion of staff training would further enhance the quality and safety of care and support provided to residents.

Regulation 15: Staffing

The skill-mix of staff was not in line with the statement of purpose, with regard to the numbers of nursing staff required to meet the assessed needs of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Some mandatory and refresher training programmes for some staff were required to be completed. This included; practical manual handling training, refresher training in safeguarding, hand hygiene and donning and doffing PPE. In addition, training in SASS was required for seven staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO1.

At the time of the inspection the inspector was informed that all 10 meetings and committees had commenced. For example, the inspector was informed that the county level person in charge meetings were held fortnightly and that the network 'governance for quality safety service improvement' meetings chaired by the DON had commenced. In addition, the inspector was informed that the next quarterly 'safeguarding review meeting' was due to be held the week of the inspection. The centre level meetings between person in charge and DON had commenced and these minutes were available for review. With regard to the staff governance meeting within the centre, the person in charge had a schedule in place to ensure that these meetings occurred bi-monthly in line with the compliance plan.

However, the oversight and monitoring of Sliabh Glas required further improvements so that the systems in place effectively identified areas for improvement to ensure a quality and safe service at all times. In addition, while the training for persons in charge in 'incident management and safeguarding training' was now complete, this had not been completed within the agreed time frame by the end of April 2022. This demonstrated that improvements were also required in the oversight and monitoring

of actions in the provider's overview report to ensure that the agreed actions to enhance the protection of residents were in place.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge ensured that all notifications that were required to be submitted to the Chief Inspector were completed in line with the regulations.

Judgment: Compliant

Quality and safety

The inspector found that residents living in Sliabh Glas were provided with a person-centred service and that the service strived to ensure that residents' wellbeing and personal needs were met. However, improvements were required to ensure that care plans clearly documented the supports required, that personally identifiable information was protected at all times, that risks were appropriately documented and that appropriate fire safety arrangements were in place.

The inspector reviewed a sample of residents' care and support plans. It was found that annual review meetings took place with the maximum participation of residents and their representatives, where relevant. Residents were found to have up-to-date assessments completed of their health, personal and social care needs. These assessments informed the development of a range of care plans to guide staff in the supports required for specific assessed needs. However, the inspector found that there was inconsistent information provided in some residents' plans. For example, some plans contained inconsistent information about whether a resident attended an external day service or not, about safe swallowing guidelines and about when to use hoists for transfers. While staff spoken with were knowledgeable about how best to support residents with their needs, the inconsistent information could create a risk if there were new staff working in the centre.

The inspector found, through discussions with staff and reviewing documentation, that residents were supported to achieve the best possible health and wellbeing, and that they were involved in their care planning. Residents were facilitated to access a variety of allied healthcare professionals and they had access to multidisciplinary team (MDT) supports, as required. There was evidence of ongoing monitoring of identified health risks, such as regular weight checks where a resident was at risk of losing weight. End-of-life care planning had been discussed with residents, as appropriate.

Some residents required supports with behaviour management and were found to have care and support plans in place. A review of behaviour support plans found that these were comprehensive and included strategies for staff to support residents with specific behaviours. Plans were found to be kept under regular review for any changes that may be required. One resident's behaviour support plan was noted to be currently under review by the relevant multidisciplinary team member. A sample of restrictive practices was reviewed and were found to be assessed to ensure that they were used for the shortest duration and were proportionate to the risks. Clear protocols were in place to guide staff in their use.

The inspector reviewed safeguarding practices in the centre and found that residents were safeguarded against any potential abuse. Residents reported that they got on well with each other, and felt safe. Residents spoken with said that they could go to the 'designated officer' or to staff if they had any concerns. Where any concern arose, these were followed up in line with the safeguarding procedures and safeguarding plans were developed, as required. Residents had intimate and personal care plans in place to guide staff in the supports required in line with individual needs and preferences. There were easy-to-read documents available for residents to help support their understanding of keeping safe. In addition, regular house meetings occurred where discussions about keeping safe occurred. The centre team meetings and meetings between the person in charge and DON also included discussions about safeguarding. As part of the provider's actions from the overview report, the provider was to implement a safeguarding tracker log for each network area by the end of March 2022. The person in charge showed the inspector the safeguarding plan tracker that had been developed for monitoring active safeguarding plans in the area that Sliabh Glas formed part of. However, some of the provider’s actions for strengthening safeguarding systems as part of the overview report action plan had not been implemented within the time frame agreed. This included a review of the audit schedule and tool pertaining to safeguarding used in centres, which was due for completion by the end of April 2022. This was reported to be in progress at the time of the inspection.

In general, the inspector found that residents’ rights were promoted in the centre. Some residents had been supported to seek advocacy services, and there was evidence that staff members were strong advocates for residents. For example, there was evidence of staff advocating for one resident to return their day service which was provided by an external provider. However, the use of information as part of the provider’s six monthly audit and annual report required review to ensure that there was no information included that could personally identify a resident and their specific care and support needs.

There were systems and procedures in place for risk management and risk escalation. Risks affecting residents that were assessed and rated as ‘high’ had been escalated by the person in charge. There were emergency plans in place and a risk register for centre-related risks. In general, each resident had been assessed for any risks that may impact their safety and well-being. However, the centre's fire risk assessment did not identify fire risks in one part of the centre, and risks that the inspector was informed about in relation to one resident’s specific needs and fire containment arrangements had not been assessed appropriately. This is included as

an action under Regulation 28. In addition, improvements were required in ensuring that the risk ratings were in line with the provider's policy and procedures. For example, some risk ratings on the centre's risk register were not calculated in line with the risk matrix, therefore giving an inaccurate risk score.

As mentioned previously, the inspector issued an urgent compliance plan with regard to fire safety. The inspector was informed that a recent review of fire doors had been completed and that a plan was in progress to address issues with some fire doors in the main house due to possible damage caused by a wheelchair. The inspector was informed that these doors would be effective in the containment of fire, but there was no report available for review to verify this. In addition, the inspector observed two doors in the self-contained flat being held open by a wedge and curtain ties. The centre fire risk assessment was reviewed and it was found to be non-specific to the arrangements in the self-contained flat and the specific needs of the resident who lived there. Furthermore, the fire safety checks in place did not include a full review of the arrangements in this area of the centre and both the local and provider audits failed to identify these risks. In addition, the recording of fire drills required review to ensure that it was clear that all residents could be safely evacuated under the scenario of when all residents were in bed.

In summary, the inspector found that in general residents' health and wellbeing were promoted and that the service was person-centred. However, some risks in relation to fire safety had not been appropriately identified and assessed. Improvements were also required in ensuring that clear and consistent information was included in residents' care plans, that personal information was respected at all times and that actions identified by the provider to strengthen the safeguarding arrangements were fully implemented within the time frames outlined in the overview report action plan.

Regulation 26: Risk management procedures

In general, risks were found to be assessed and kept under review where they had been identified. However, some risk ratings required review to ensure that they accurately reflected the risk score in line with the provider's risk management procedures and risk matrix.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed.

On the day of inspection, the inspector found that the provider did not ensure that there were adequate arrangements in place for effective fire protection. The following issues were identified;

- Two doors in the apartment that formed part of Sliabh Glas were held open, one by a door wedge (a resident's bedroom) and one with a curtain tie-back (door leading from kitchen/living area to the hallway).
- The fire risk assessment in place was not specific to the apartment or based on the assessed needs of the resident living there, with no evidence of any assessment of specific fire risks as identified on the days of inspection.
- It was not clear on the 'Fire book' that checks were occurring in the apartment as well as the main house, and conflicting information was given to the inspector about checks in the apartment.
- There was no documentary evidence available for review on the day to confirm that the existing fire doors had been inspected by a competent person to ensure that they were effective in the containment of fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An assessment of needs was completed for residents, to assess their health, personal and social care needs. Annual review meetings were held with the maximum participation of residents and their representatives. However, some care and support plans required updating as they contained inconsistent information on attendance at day services and in the supports a resident required in personal care and to ensure safe swallowing guidelines were clear.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health and wellbeing, by being supported to access allied healthcare professionals and medical appointments as required. Residents' healthcare needs were found to be kept under regular review.

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 relating to positive behavioural support at the centre. One action related to the approval of MDT supports, three actions related to staff training and in ensuring staff have knowledge about behaviour support plans and three actions related to the induction of new staff.

At the time of the inspection, the inspector was informed that the one action relating to the approval for additional MDT supports was in progress. With regard to staff training, there was evidence that a review of training was discussed at the person in charge and centre level meetings. In addition, with regard to a training needs analysis, the person in charge maintained an 'Annual Training Plan for 2022', which outlined when staff were due to complete training. One staff member who was appointed three weeks previous was scheduled for behaviour management training the following week, however there were no dates set for two regular agency staff to complete behaviour management training.

In relation to actions regarding induction of new staff, the inspector reviewed the induction checklist in place for one recently appointed staff and also spoke with the staff member. They talked about the range of training that they had completed, and about further training that was scheduled for them. They spoke about how they shadowed staff for three shifts as part of their induction. The person in charge informed the inspector about their arrangements to monitor that staff had read behaviour support plans, which included the requirement for all staff to sign off on residents' personal files (which included behaviour management plans) rather than individual behaviour support plans.

Residents who required supports with behaviours of concern had plans in place which included multidisciplinary input. Restrictive practices were found to be assessed and kept under regular 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 relating to protection at the centre. At the time of this inspection, eight actions had been implemented and five actions were in progress. For example, the safeguarding review meetings had commenced and the safeguarding tracker log had been implemented. In addition, training needs were found to be reviewed at centre and person in charge level. In relation to a ‘Policy on the provision of safe WiFi usage’, this was reported to be in progress for completion.

However, not all actions that had been completed within the time frame outlined in

the overview report action plan. For example, the person in charge informed the inspector that a review of the audit tool for safeguarding was in progress; however this was due to be completed by the end of April 2022.

The impact of the provider's enhanced oversight and monitoring as detailed above was not yet evident, as these processes were in the early stages or in process for implementation. However, on this inspection the inspector found that safeguarding measures and processes in the centre ensured that residents' safety was promoted.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The unannounced provider report and annual review of the service required review to ensure that information in the reports did not include information that could possibly identify a resident and their personal information.

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 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sliabh Glas OSV-0002518

Inspection ID: MON-0031145

Date of inspection:24/05/2022 and 25/05/2022

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 • Approval has been received for a temporary staff nurse and awaiting appointment of personnel by HR Completion date: 31-12-2022 • A recruitment campaign for staff nurses within disability services inclusive of graduate nurses who will qualify October/November 2022 has commenced with interview planned for the week commencing 27-06-2022. In the interim a number of consistent agency staff are covering the shifts.	
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 • Positive behavior support – 2 regular agency staff require this training. This training is scheduled for 28-06-2022 29-06-2022 with and additional date 31-08-2022. • Supporting Sexuality in Supported Settings – 5 staff require this training, 3 HSE and 2 regular agency staff. This training is scheduled for 29-06-2022 and 13th July 2022 • Primary Food Hygiene – 2 staff require this training. This training is scheduled for 30-	

06-2022.

• Manual Handling – 1 staff require this training. This training is scheduled for 21-07-2022.

• Refresher Safeguarding Training- 1 staff required this training. Completion date: 21-06-2022.

• Hand Hygiene Training – 1 staff required this training. Completion date: 12-06-2022

• PPE Donning & Doffing 2 staff required this training. Completion date: 12-06-2022

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance with regulation 23: Governance and management: the following actions has/will be taken.

• The centre has an audit schedule in place, with the PIC completing a number of audits on a monthly basis. Actions arising from audits are place on the centres QIP for follow up and close out. Completed audits are reviewed by the DON in conjunction with the PIC as part of the individual PIC meetings. The most recent individual PIC meeting took place on the 27-06-2022.

• The self – assessment judgement framework is completed by the PIC on a quarterly. Actions arising from the SAJF is be placed on the centre's QIP for follow up and closing out. Date of last self- assessment 11-04-2022

• The service has a schedule in place for the completion of the Unannounced Provider Nominee Visits to the centre. The first PN visit for 2022 was completed on the 29-03-2022. Actions arising from the PN visit was included on the centres QIP for follow up and closing out.

• The service has a schedule in place for the completion of the annual review of the services. Most recent annual review of the centre took place on the 29-10-2022.

• Bi – monthly individual PIC meetings with the Director of Nursing. These meetings follow standard agenda items. Action arising from these meetings are added to the centres QIP for follow up and closing out. The most recent individual PIC meeting took place on the 27-06-2022.

• Bi- monthly staff governance meeting takes in the centre. The most recent meeting

took place on the 20-06-2022.

• There is a schedule in place for the safeguarding review meetings which takes place on a quarterly basis where individual safeguarding plans are reviewed, and trends identified. The most recent safeguarding review meeting took place on the 28-05-2022

• There is a schedule in place for the quarterly quality safety service improvements meetings chaired by the DON. The most recent meeting took place on the 28-05-2022.

The centre has a QIP which is reviewed on a monthly basis, by the PIC and the DON.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure compliance with regulation 23: Risk Management Procedures: the following actions will be taken

• The centre has a Health and Safety Statement which identifies all risk in the centre and control measure in place to mitigate risks identified. The PIC has reviewed and updated all the risk assessments to ensure risk descriptions and risks ratings are accurately recorded. Completion date: 17-06-2022

• The PIC/named nurse will review all individual risk assessments to ensure the risk descriptions and risk ratings are accurately recorded. Completion date: 31-07-2022

• A behavior support plan for one resident will be updated following review by the psychologist. Completion date: 31-07-2022

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance with the regulation 28 Fire, the following actions has/ will be taken

1. On the 25th May 2022 the Director of Nursing held an emergency meeting with the Person In Charge and staff from Sliabh Glas Community Group Home. At this meeting the following was discussed and agreed.

• The immediate removal of the wedges from doors.
• Discussion with all present on the risks associated with fire doors being wedged open.
• A memo has been issued to all staff in relation to the necessity of not wedgeing doors open in this centre. Completion date: 01-06-2022
• The requirement for all staff to complete refresher fire training this has been scheduled Completion Dates: 02-06-2022 and 08-07-2022.

2. The Regional Fire Prevention Officer visited the centre on the 30-05-2022 and provided the following report

The current doors in the apartment are FD30 fire doors, however the Regional Fire Protection Officer has recommended that the three doors in question are changed to bring them up to the current FD30S standard.

3. The PIC has developed a fire risk assessment for the flat reflecting current controls in place and additional controls being put in place to mitigate risk. Completion date: 01-06-2022
• Upgrading of the three fire doors to include closures as per recommendations from the Regional Fire Prevention Officer. Completion date: 31-08-2022.
• A separate Fire Book in the flat attached to Slabh Glas Community Group Home has commenced on the 31-05-2022. This will ensure that both Fire Books accurately reflects the fire checks completed in both areas. All staff working in the centre have been informed of this new arrangement. Completion date 01-06-2022.
• The PIC will complete fire questionnaires with all staff in Sliabh Glas. Completion date: 10-06-2022.
• The PIC has repeated the night- time fire drill for the centre. The recording of this fire drill has reflected the location of each resident at the time of the fire drill. Completion date: 01-06-2022.
• Weekly checks will be completed by the PIC to ensure fire doors are not wedged open. Commenced on the 30-05-2022.
• The PIC will ensure that fire compliance is a standing Agenda item at Staff Meeting in Sliabh Glas and Local Governance Meetings Letterkenny.
• All staff in Sliabh Glas will complete refresher fire training. Completion date: 02-06-2022 and 08-07-2022.
• All staff in Sliabh Glas will complete the following training on HSELand
1. Your Safety Health and Welfare in Health Care Completion Date: 24-06-2022
2. NHSF Occupational Safety and Health Risk Assessment Webinar. Completion date: 17-06-2022.
• The PIC will complete training in Managing Health & Safety in Healthcare Settings. Completion date: 10-06-2022.
• The PIC will update the centers training matrix to reflect training completed by staff in Sliabh Glas as part of this compliance plan

Regulation 5: Individual assessment	Substantially Compliant

and personal plan	

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
To ensure compliance with regulation 5: Individual assessment: the following actions will be taken

• The PIC/named nurse will review all care plans to ensure the plans accurately reflect the needs of the residents. Completion date: 31-07-2022

• A behavior support plan for one resident will be updated following review by the psychologist. Completion date: 31-07-2022

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 behavioural support: the following actions will be taken

• Positive behavior support – 2 regular agency staff require this training. This training is scheduled for 28-06-2022 29-06-2022 with and additional date 31-08-2022.

• A behavior support plan for one resident will be updated following review by the psychologist. Completion date: 31-07-2022

• Additional MDT support – National approval to recruit Health & Social Care Professionals for Donegal has been secured as follows:

• 2 senior social workers
• 2 senior Speech and Language Therapists
• 2 senior Psychologists

Recruitment is being progressed by HR

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

• Supporting Sexuality in Supported Settings – 5 staff require this training, 3 HSE and 2 regular agency staff. This training is scheduled for 29-06-2022 and 13th July 2022

• The Regional Director of Nursing in conjunction with Director of Nursing has completed a review of the audit schedule Completion date: 30-04-2022. A number of actions have been identified following the review and these are currently in progress to be closed out by the 30-09-2022.

• The incident Management & Safeguarding Training for all persons in charge has been completed. Completion date: 19-05-2022

• The service is currently developing a Donegal policy on the provision of safe Wifi usage in conjunction with the Digital Health Lead, Health and Social Care professionals and in consultation with other care group services. Completion date: 31-12-2022.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure compliance with regulation 9: Resident's rights: the following actions will be taken

• The DON/CNM 11 with a responsibility for completing unannounced provider reports and the annual reviews attended an information session delivered by the Regional Director of Nursing CHO 1. Staff with the responsibility for completing unannounced provider reports and the annual reviews will ensure that the information in the reports do not include information that could possibility identify a resident and their personal information. Completion date: 12-05-2022

• The completion of unannounced provider reports and the annual reviews was discussed at the fortnightly Donegal Person In Charge (PIC) meeting held on 02-06-2022. Staff with the responsibility for completing unannounced provider reports and the annual reviews must ensure that the information in the reports did not include information that could possibility identify a resident and their personal information. Completion date: 02-06-2022.

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(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.	Substantially Compliant	Yellow	31/12/2022
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	31/08/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/12/2022

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	31/08/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	31/08/2022
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	31/08/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	31/08/2022
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with	Substantially Compliant	Yellow	31/07/2022

	any changes recommended following a review carried out pursuant to paragraph (6).			
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	31/08/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	02/06/2022