



# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

Name of designated centre:	Ballytrim House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	26 May 2022
Centre ID:	OSV-0002523
Fieldwork ID:	MON-0034374

## About the designated centre

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

Ballytrim House provides residential care and support to adults with a disability. The designated centre comprises an eight bedded one-storey building located in a residential housing estate in a small town. Residents living at the centre have access to communal facilities such as sitting rooms, a sensory room, dining room, kitchen and outdoor area. Each resident has their own bedroom with en-suite bathroom. The centre also has additional communal bathroom and toilet facilities. Ballytrim House is located close to local amenities such as shops, public houses and cafes. There are three vehicles available which enable residents to access other amenities in the surrounding area such as swimming pools and other leisure facilities. Residents are supported night and day by a staff team of both nursing and care staff.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	7
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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
Thursday 26 May 2022	11:30hrs to 18:00hrs	Alanna Ní Mhíocháin	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 behavioural 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.

This centre consisted of a large single storey building in a housing estate on the edge of a town. Each resident had their own bedroom and en-suite bathroom. Residents' bedrooms were decorated in individual styles in line with residents' tastes and wishes. Some residents also had their own sitting rooms that were decorated in different styles. In addition, residents shared two sitting rooms, a sensory room, dining room, kitchen, utility room and bathroom with a large bathtub. There were also a number of store rooms in the centre. The person in charge reported that some furniture and furnishings had been recently damaged and removed. One section of the building was separated from the rest by an interconnecting door. Living arrangements in the centre had been reconfigured in recent months with one resident moving from the main part of the building into this annex. This resident, in addition to their en-suite bedroom, had their own dining room and sitting room. The interconnecting door remained open throughout the day so that the resident could access the rest of the centre. The person in charge reported that this reconfiguration had reduced the number of negative interactions between residents and therefore, reduced the number of safeguarding incidents that occurred in the centre. This will be discussed further in another section of the report. Outside, there was an enclosed space with a lawn, swing-set and space to sit out. The person in charge reported that there were plans to improve this area of the centre. There was a broken trampoline that was due to be replaced with a new in-ground trampoline. Fencing around the centre was also due to be repaired and replaced.

The inspector met with six of the seven residents in the centre at various times throughout the inspection. Residents had different schedules and activities during the day. Some left the centre to attend day services, go to the shop or go for an outing. Other residents engaged in activities in the centre with the support of staff. Two residents told the inspector that they were happy living in the centre. Another resident spoke about the outing that they were going on. Residents were noted

moving around the centre as they wished. Residents were observed making choices in relation to their evening meal. Some residents watched television or listened to music.

Staff interacted with residents in a caring and friendly manner. They were familiar with the residents' communication style. Staff successfully used specific communication techniques with some residents. This included the use of gesture and communication devices. Staff were noted offering choices to residents in relation to their food, activities and preferred television show. Staff were quick to respond when residents requested help. Staff were noted knocking and requesting permission before entering residents' bedrooms. Staff were respectful when they spoke about residents and were knowledgeable of their individual needs and preferences.

Overall, residents were treated with dignity and respect. Staff interacted with residents in a friendly manner and respected their choices. Staff were knowledgeable on the needs of residents. However, improvement was required in relation to the implementation of certain aspects of the provider's compliance plan within the timeframes specified and in relation to documentation. This will be outlined in the next two sections of the report. These 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 each resident.

## Capacity and capability

As outlined above, the provider had submitted a compliance plan in response to the findings from the targeted inspections in January 2022. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in the centre. This included the introduction of regular meetings within the centre and across the service in the county. The person in charge and a member of senior management gave information on the commencement of these scheduled meetings.

Within the centre, staff governance meetings occurred on a bi-monthly basis. This meeting happened on the day of inspection and was concluding as the inspector arrived at the centre. Five members of staff who were not rostered to work came into the centre to attend the meeting. The topics discussed at this meeting included issues specific to the care and support of residents, for example, safeguarding, clinical issues, quality, and risk. It also included discussion on operational issues in the centre, for example, staffing, training, cleaning allocations, and booking annual leave. The person in charge reported that minutes of the meeting would be available for all staff and that staff would be expected to sign to show that they had read the minutes. In addition to the staff meeting, the person in charge and the director of nursing met on a bi-monthly basis to review the service in the centre. These

meetings had recently commenced in line with the provider's compliance plan.

On a county and network level, it was evident from discussion with the person in charge and director of nursing that the meetings outlined in the provider's compliance plan had commenced in line with the timeframe set out. These meetings were in the early stage of development and therefore required further time to be established and show an improvement to the lived experience of residents. For example, the Human Rights Committee was still in the process of drawing up terms of reference for the group with the next meeting scheduled to take place on 02/06/2022. The process of dissemination of information from senior management meetings to persons in charge had not yet been fully established. The person in charge was not aware if meetings within the county at a more senior management level had commenced and minutes from these meeting had not been circulated to the person in charge. However, the director of nursing reported that relevant issues from senior management governance meetings would be communicated to the person in charge during the bi-monthly meetings between the director of nursing and person in charge.

There were clearly defined management structures in this centre. Staff in the centre received supervision from the person in charge. Supervision sessions followed a set agenda that covered issues relating to staff development and issues relating to the service in the centre. The person in charge had a schedule in place to plan staff supervision sessions. In addition, the person in charge received supervision from their line manager. There was an identified team leader for each day and night shift on the roster.

The provider had completed an annual review of the quality and safety of care and support delivered in the centre. The report covered a broad range of issues within the service and included input from residents. It identified areas for service improvement. However, the action plan generated from the report listed broad general goals without identifying specific actions or target completion dates. The most recent six-monthly unannounced audit of the centre was completed on 06/04/2022. This audit gave a comprehensive overview of the service and, in contrast to the annual review, identified specific actions for service improvement with timeframes for completion.

The compliance plan that the provider submitted in response to the targeted inspections in January 2022 outlined that a review of the audits in designated centres in Co. Donegal would be completed by April 2022. The inspector viewed an email that was circulated to all persons in charge in March 2022 asking for input into the review process. However, on the day of inspection it was noted that this review had not yet been completed. There was an existing schedule of audits in the centre. The schedule outlined when certain audits should be completed. The inspector noted that audits had been completed in line with this schedule. Findings from audits were included in the centre's quality improvement plan. In addition to audit findings, the plan outlined service improvements that were identified through previous HIQA inspections, the provider's six-monthly audits, senior management evaluations, risk assessments, self-assessment completed by the person in charge, and the quality improvement team. The plan also included maintenance issues, for

example, the acquisition of a new trampoline, painting in the centre and plans to replace damaged items of furniture. The quality improvement plan had specified actions and target dates for completion. It was reviewed and updated monthly.

Staffing arrangements in the centre were adequate to meet the assessed needs of residents. A review of the centre's rosters showed that the number and skill-mix of staff on duty were appropriate to meet the residents' needs. Nursing staff were available at all times in the centre. Agency staff were employed in the centre. This consisted of a regular team of staff who were familiar to the residents.

Staff training records in the centre were reviewed. The provider had identified 23 mandatory training modules for staff and 11 modules that were site specific. Records indicated that most staff had up to date training in all modules. For some modules, where staff required training, specific training dates had been identified in the coming week. However, there were a number of modules where staff required updated training. Many of these modules related to infection prevention and control. For example, six staff required training in standard precautions and seven staff required training in aseptic technique. On the day of inspection, the person in charge sent all staff a copy of their personal training record with outstanding training courses highlighted for their attention. Sexuality awareness in supported settings (SASS) was identified in the provider's compliance plan as a module that was required by all staff working in designated settings in Co. Donegal. All staff members, except one, had received this training in this centre.

Overall, the introduction of governance meetings had strengthened the management arrangements in the centre. However, as they were newly established, further time was required to determine if they had a positive impact on the lives of the residents.

### Regulation 15: Staffing

The number and skill-mix of staff in the centre were adequate to meet the assessed needs of residents. The person in charge maintained a planned and actual staff roster. Nursing support was available at all times in the centre. The staff team were familiar to residents, this included regular members of agency staff, ensuring that residents received continuity of care and support.

Judgment: Compliant

### Regulation 16: Training and staff development

The provider had identified a number of mandatory training modules for all staff and additional site-specific training modules for this centre. While the majority of staff were up to date in their training, there were a number of modules where staff



required updated training. These modules generally related to infection prevention and control. In some cases where staff required training, specific training dates had been identified. However, this had not occurred in all cases. For example, three staff required training in cardiopulmonary resuscitation but no specific dates for this training had been identified by the person in charge.

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; 10 actions relating to governance meetings and one action relating to an audit review.

At the time of inspection, the 10 actions relating to governance meetings at county, network and centre level had commenced and were in the early stages of development. For example, the Human Rights Committee were in the process of establishing their terms of reference and the Policy Procedure Protocol Guidelines (PPPG) Development Group were planning to target existing policy documents that were due for review. The person in charge spoke of the fortnightly meeting between all persons in charge in the county and the network Safeguarding Review Meeting as being beneficial for shared learning between centres. The process of dissemination of information from senior management meetings to persons in charge had not yet been fully established. However, assurances were given by the director of nursing that relevant information from senior management would be shared during the bi-monthly meetings between the director of nursing and the person in charge. The new governance meeting arrangements required further time to be established and show an improvement to the lived experience of residents.

One action in the provider's compliance plan related to an audit review. This was due for completion in April 2022. It had commenced but had not been completed in line with the target date in the provider's compliance plan.

There was oversight in the centre through the use of the existing audit schedule. The provider had completed the annual review and required six-monthly unannounced audits of the quality and safety of care and support in the centre. While the identified service improvements in the six-monthly audit clearly outlined target actions, the identified service improvements in the annual review were not specific and did not give target dates for their completion.

Judgment: Substantially compliant

## Quality and safety

There was good practice noted on this inspection in relation to the quality and safety of care provided to residents. Safeguarding plans were implemented where required and residents received supports in line with their assessed needs. However, improvement was required in relation to documentation relating to resident's risk assessments, assessments of need and the administration of medication to support residents manage their behaviour.

The provider had commenced a number of the actions relating to safeguarding that were identified in the compliance plan submitted following the targeted inspections in January 2022. The person in charge reported that they had completed incident management and safeguarding training as outlined in the compliance plan. As discussed previously, most staff in the centre had completed SASS training. The network level safeguarding review meetings had commenced. The person in charge reported that these meetings provided an opportunity to share learning between centres and to provide feedback on existing safeguarding plans. The safeguarding tracking log was discussed at these meetings. However, when asked about the training needs analysis, the person in charge reported that they had been asked to submit information in relation to the existing training matrix in the centre but had not been asked to identify any additional training areas that staff in the centre may require. Also, the person in charge was a member of the PPPG group and reported that a policy on safe Wi-Fi usage had not yet been included on the agenda of that committee.

Safeguarding issues in the centre related to negative interactions between residents. There were a number of open safeguarding plans in the centre on the day of inspection. These plans provided clear steps that staff should take to protect residents and to avoid reoccurrence of any incidents. There was also a safeguarding tracking log that provided an overview of safeguarding issues in the centre and allowed for an analysis of any trends that may emerge. Safeguarding incidents were reported to the national safeguarding team. There was evidence that safeguarding plans were progressed and closed out when appropriate. To address issues relating to compatibility between residents, one resident had recently moved to an annex in the building as outlined previously. To further reduce any negative interactions, there was a planned multidisciplinary meeting to discuss the possibility of creating a separate entrance to the annex so that it could be self-contained and separate to the main building. In addition, there was a plan for some residents to move to a new designated centre. The provider had been asked to submit an outline of the decongregation plan for the centre as part of the inspections in January 2022. The person in charge provided information to indicate that the plan was progressing in line with the timeframe that had been submitted. Staff for the centre had been recruited and were currently working in other centres until the planned refurbishment works in the new centre were complete. This was due for completion at the end of 2022.

Residents had behaviour support plans that outlined steps that should be taken by staff to support residents remain calm and to support them if they became upset or anxious. There was evidence of input from relevant healthcare professionals in the

development of the plans and support of residents. This included clinical psychology and psychiatry services. The inspector reviewed a sample of plans and noted that immediate issues and an escalation of challenging behaviours were promptly addressed with onward referral to appropriate supports. However, documentation in relation to one resident's plan that was reviewed required updating. The plan was dated 2019 but the resident had been reviewed by behaviour support services in recent weeks and this was not reflected in the document in the resident's personal plan. In discussion with staff, they were knowledgeable on the content of the plans and the actions that should be taken to support residents manage their behaviour. A number of restrictive practices were implemented in the centre. A record of these were kept in a restrictive practice log. This log outlined the protocol for the implementation of the restrictive practice and a record of its use. The protocol for the administration of medication to a resident with behaviours that challenge was reviewed. The protocol clearly outlined the medication, the required dose and the amount that could be administered in a 24 hour period. However, further clarity was required in relation to the specific criteria that would warrant the administration of the medication. This resulted in a risk that medication could be given inappropriately and may not be the least restrictive procedure for the resident.

Positive behaviour support was also part of the provider's compliance plan. Discussion with the person in charge indicated that some aspects of the plan had been commenced. As discussed previously, a training needs analysis was completed but did not include identification of gaps in staff training. Training schedules were included in the centre's meeting agenda and were discussed at the meeting held in the centre on the day of inspection.

The inspector reviewed a sample of residents' care and support plans. Residents had annual review meetings that included input from the resident and members of the multidisciplinary team. In the case of one resident, their annual review had been completed on 09/05/22 but on the day of inspection, two weeks later, this information had not been added to the residents' folder to guide staff and not all associated care plans were up to date as a result. The resident's personal plans identified health, social and personal needs and set goals to support residents meet those needs. There was evidence that the goals were routinely reviewed and updated. There was evidence of input from a variety of healthcare professionals as required. Each resident had a named general practitioner and referrals had been made to specialist health services if needed. The protocol for the administration of emergency medication in case of a prolonged seizure for one resident was reviewed. The protocol gave clear indications on when this medication should be administered and staff were knowledgeable on the criteria and method of administration.

Individual risk assessments were included in residents' personal plans. A review of a sample of individual risk assessments found that some required updating. One resident's risk assessments were due for review in July 2021 but this had not been documented. In another assessment, the control measures listed related to a different resident. The person in charge maintained a risk register for the centre that covered the risks to the service as a whole. A review of this register found all risks to be reviewed in line with the provider's guidance. Control measures to reduce the risk were identified. The risk register was comprehensive and specific to the service.

Risks that were noted on inspection had been identified by the person in charge and risk assessments were in place in response to these risks.

Staff were knowledgeable on the communication needs of residents. Staff were observed using picture-based communication systems and gesture with residents to support them to make choices and indicate their wishes. Staff were responsive to residents' communication style. Residents had access to adaptive technology to assist with their communication. They also had access to appropriate media devices, for example, television, radio and internet access.

The centre had an industrial style kitchen. Residents' main meals were cooked off-site in a local hotel and delivered to the centre daily. There was a set weekly menu and residents had a choice of two main meal options daily. The meal choices and menu planning was discussed at residents' weekly meetings. In addition to the delivered meals, there was ample food in the centre for residents to cook their own meals and for snacks and refreshment. Residents were supported to go grocery shopping if they wanted. Residents were observed choosing their own meals and staff were available to provide appropriate support to residents at mealtimes if required.

In summary, it was found that there was good practice in the centre and residents were in receipt of a good service. Improvement was required in relation to documentation relating to individual risks to residents, the residents' assessed needs and the administration of medication to support residents' behaviour.

### Regulation 10: Communication

Staff were knowledgeable on the supports required by residents to communication their needs and wishes. Staff were observed using communication strategies with residents effectively. Residents had access to appropriate media, for example, tablet computers, television, radio and internet.

Judgment: Compliant

### Regulation 18: Food and nutrition

Residents had access to meals, refreshments and snacks at all times. Residents were provided with wholesome and nutritious food and had choices at mealtimes. Residents were supported to plan meals and to go grocery shopping if they wished. Residents were supported appropriately at mealtimes.

Judgment: Compliant

## Regulation 26: Risk management procedures

There was a comprehensive risk register in the centre that identified risks to the service as a whole. Control measures to reduce the risk were identified. The risk assessments in the risk register were specific to the centre and the service. They were regularly reviewed. However, some risk assessments relating to individual residents required updating and review to ensure that they were specific to the needs of the resident.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Residents had an annual review of their care with involvement from the resident and members of the multidisciplinary team. Personal plans that identified the residents' health, social and personal needs and goals were devised. There was evidence that these goals were reviewed and updated regularly. However, documentation in relation to some residents' assessment of need and corresponding care plans required updating.

Judgment: Substantially compliant

## Regulation 6: Health care

Resident healthcare needs were well managed. Residents had a named general practitioner. There was access to different healthcare professionals as required by residents. Referrals had been made to specialist healthcare services when needed.

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 ensuring staff have knowledge about behaviour support plans and

three actions related to the induction of new staff.

The inspector reviewed three of these actions on the day of inspection; the approval of MDT supports and two actions relating to staff training. The inspector found that these actions had commenced but were not all complete. However, the provider's timeframe for the completion of these actions had not elapsed on the day of inspection. Regarding the approval of MDT supports, the inspector was informed that these posts were in progress. Regarding training, the person in charge had been asked by senior management to submit information in relation to the existing training records in the service. The identification of specific training needs in the centre had not been requested. Training schedules had been discussed at the centre governance meeting held on the day of inspection.

Staff in the centre had received training in relation to supporting residents manage behaviours that are challenging. Two members of staff who required training in this area were booked on a training course the following week. Residents had behaviour support plans. There was evidence of input from clinical psychology, psychiatry and clinical nurse specialists in behaviour support as required by residents. However, improvement was required in relation to the documentation of input from these professionals. Also, a protocol for the administration of medication to support residents manage their behaviour was not sufficiently detailed to give clear guidance to staff on when the medication should be administered.

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.

The inspector reviewed eight of the actions on this inspection. At the time of inspection, six of these actions had been commenced and some completed.

- The person in charge had completed incident management and safeguarding training
- A network safeguarding tracking log had been implemented
- The person in charge had provided information on staff training to senior management. However, as outlined previously, specific training needs for staff in this centre had not been requested or identified.
- Training schedules were included as agenda items in the minutes of governance meetings
- Staff in the centre had received training in SASS
- The network safeguarding review meetings had commenced.

However, two actions that were reviewed had not yet commenced.

- The review of the audit schedule and tool pertaining to safeguarding had not been completed despite a target date of April 2022 set out in the plan.
- The 'policy on provision of safe WiFi usage' had not yet commenced. However, the provider's timeframe for completion of this action had not yet elapsed on the day of inspection.

There were good safeguarding practices in the centre. Safeguarding plans were in place where needed and staff were knowledgeable of their content. The plans gave clear guidance to staff on how to manage safeguarding risks in the centre. There were plans to address issues of compatibility between residents and plans for residents to move to a new designated centre were in progress. Staff had received training in safeguarding.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially 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



# Compliance Plan for Ballytrim House OSV-0002523

Inspection ID: MON-0034374

Date of inspection: 26/05/2022

## 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 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <ul style="list-style-type: none"> <li>• Standard Precautions – 6 staff require this training. Completion date 14/07/2022</li> <li>• AMRIC Aseptic Technique – 7 staff require this training. Completion date 14/07/2022</li> <li>• Supporting Sexuality in Supported Settings – 1 staff required this training – Completed April 2022, now updated on training matrix Completion date 15/06/2022.</li> <li>• CPR – 3 staff require this training – Completion date 31/08/2022</li> </ul>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> <li>• 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 specific actions will be noted with dates for completion. Completion date: 12-05-2022</li> <li>• 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.</li> </ul> <p>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</p>	

consultation with other care group services. Completion date: 31/12/2022.	
Regulation 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <ul style="list-style-type: none"> <li>• The PIC has completed a review of all residents risk assessments to ensure correct and accurate information – Completion date 15/06/2022</li> <li>• The PIC has completed a review of residents risk assessments to ensure review dates noted – Completion date 15/06/2022</li> </ul>	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <ul style="list-style-type: none"> <li>• The PIC has completed a review of all residents risk assessments to ensure correct and accurate information – Completion date 15/06/2022</li> <li>• The PIC has completed a review of residents risk assessments to ensure review dates noted – Completion date 15/06/2022</li> <li>• The PIC continues to liaise with MDT to complete assessment of need, reports and care plans updated to reflect any changes – Completion date 31/08/2022</li> <li>• The PIC has ensured care plans updated within a timely manner following annual review – Completion date 15/06/2022</li> </ul>	
Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <ul style="list-style-type: none"> <li>• The PIC has completed a review of all residents risk assessments to ensure correct and accurate information – Completion date 15/06/2022</li> <li>• The PIC has completed a review of residents risk assessments to ensure review dates</li> </ul>	

noted – Completion date 15/06/2022

- The PIC has reviewed BSP along with MDT and updated PRN protocol to reference BSP offering staff more guidance on criteria for administration – Completion date 15/06/2022
- The PIC has reviewed all residents BSPs to ensure all reviewed in line with policy – Completion date 15/06/2022

• 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

- 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 8: Protection

Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

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

## 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 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 place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	15/06/2022

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	31/08/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	15/06/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022