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

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| Name of designated centre: | Moville Residential Group Home |
| Name of provider: | Health Service Executive |
| Address of centre: | Donegal |
| Type of inspection: | Unannounced |
| Date of inspection: | 16 November 2022 |
| Centre ID: | OSV-0003339 |
| Fieldwork ID: | MON-0034859 |

## About the designated centre

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

Moville Residential Group Home provides full time residential care for four male or female adults with intellectual disabilities. The service is intended to cater mainly for residents with low to moderate needs with the aim of maximising their potential for independent living. Moville Residential Group Home is a house centrally located in a rural town, and is close to the town amenities. It is a two-storey house with gardens. All residents in the centre have their own bedrooms. Residents are supported by a staff team that includes nursing and care staff. Staff are based in the centre when residents are present and staff are on duty at night to support residents.

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

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| Number of residents on the date of inspection: | 4 |

## 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 |
|---|---|---|---|
| Wednesday 16 November 2022 | 09:15hrs to 16:45hrs | Jackie Warren | Lead |

## What residents told us and what inspectors observed

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

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

This inspection was unannounced and was carried out to monitor the provider's compliance with the regulations relating to the care and welfare of people who reside in designated centres for adults with disabilities. As part of this inspection, the inspector met with residents who lives in this centre and staff on duty, and also viewed a range of documentation and processes. The person in charge was not available but another staff member facilitated the inspection.

The centre was located in a busy town and had good access to a wide range of facilities and amenities. The centre was a large detached house, which provided plenty of space for the residents. All residents had their own bedrooms, and there were adequate bathrooms in the centre to meet the needs of residents. The centre suited the needs of the residents, and was spacious, warm, clean, comfortable and well maintained. The inspector found that the centre rooms was decorated in a homely manner with pictures and photos, and comfortable furniture. There was a well equipped kitchen and dining area which was central to life in the centre. Residents liked to gather around the kitchen table for meals, meal planning and general communal activities. On the morning of the inspection, residents were together in the kitchen planning the day ahead, and chatting and joking together and with staff. Residents were very involved in housekeeping and liked to take responsibility for keeping the centre comfortable and clean. During the inspection, the inspector saw residents doing household tasks such as vacuuming, tidying and

meal planning.

There were large gardens to both the front and rear of the building and residents enjoyed spending time on outdoor projects. The garden to the rear of the house was laid out with a selection of fruit, salad and vegetable plots, flower beds and a poly tunnel. Residents enjoyed growing their own produce, which they prepared and cooked in the kitchen at mealtimes and made preserves. Residents also used greenery from the garden to make crafts and decorative items such as Christmas wreaths and gifts. On the day of inspection, residents were out for much of the day as they were making hand made gifts for loved ones and working on Christmas projects to display at a local Christmas craft fair. They had also gone shopping with staff for materials for these projects. As this was a home based service, resident had choices around staying at the centre, doing things outdoors or in the community, or attending day services. One resident like to go to day service activities a few times a week and this was supported.

The inspector met briefly with residents as they were busy. Residents talked about some of their achievements during the year, and the inspector saw evidence of residents having considerable community interaction. It was clear that all residents in this centre were very much part of the local community and had been involved in a wide range of community projects and activities throughout the past year. Residents were very involved in the Tidy Towns movement and had competed and won several categories, including the best overall prize. They had created an piece of outdoor art representing a witch, which had been displayed in the local area for Halloween and which was also a prize winner.

Residents had been involved in several community activities throughout the year, such as keeping a portion of the beach clean, maintaining a flower bed display in the village, and one resident was working to help develop an outdoor community gym. Residents had also taken part in the St. Patrick's Day parade. One resident worked in a local business for one day each week.

Leisure activities that residents had enjoyed during the past year included, bowling, outings and holidays, visiting with friends and family, playing music, a fancy dress birthday party and social events such as going out for meals or to the pub for a pint. At the time of inspection one resident was planning the Christmas night out for residents and staff.

Overall, it was evident from observation in the centre, conversations with residents and staff, and information viewed during the inspection, that residents had a good quality of life, had choices in their daily lives, and were supported by staff to be involved in activities that they enjoyed, both in the centre and elsewhere, and were very integrated into in the local community. Throughout the inspection it was very clear that the person in charge and staff prioritised the wellbeing and quality of life of residents.

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

## Capacity and capability

Overall, the provider had measures in place to ensure that this centre was well managed, and that residents' care and support was delivered to a high standard. However, there were some governance deficits, including staffing, cover arrangement for the person in charge, personal planning documentation and inadequate resources, which presented a risk that this standard might not be consistently achieved.

The provider had submitted a compliance plan in response to the findings from the targeted inspection programme in January 2022. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in the centre. These included the introduction of regular meetings within the centre and across the service in the county.

Since the previous inspection of the centre in January 2022, significant improvement to the overall organisational management processes had taken place. These improvements included a range of governance and oversight meetings. For example, human rights committee meetings were being held quarterly, and weekly regulation, monitoring and governance meetings took place for Donegal County. The person in charge was also involved in fortnightly meetings with other persons in charge in Donegal, and told the inspector that these meetings were useful for receiving information from peers and higher management levels, and for shared learning from other persons in charge. Due to work commitments in the centre, the person in charge did not always have the capacity to attend these meetings, but acknowledged that the minutes of the meetings were always supplied for his information. He also confirmed that he was kept informed of the outcomes of a range of other management meetings taking place in the area. The inspector viewed the records of staff meetings and found that the person in charge shared information from management meetings with staff. Staff who did not attend these meetings could access the minutes in a folder in the office. However, information and outcomes of meetings could not be shared online or by email as only nursing staff had email access.

A detailed audit plan for 2022 including a range of safety and care audits had been developed by the provider to ensure that the overall quality of care and safety in the centre was being monitored. This audit plan required that some aspects of the service were scheduled for auditing more frequently than had previously been the case. At the time of the inspection, some audits were not being completed in line with the provider's new audit plan. Unannounced audits of the service were being carried out twice each year on behalf of the provider. These audits identified any areas where improvement was required, and action plans were developed to address these issues. A representative of the provider had also carried out a detailed annual review of the service.

The provider had developed a clear organisational structure to manage the service. There was a person in charge who was suitably qualified and experienced, and who worked closely with staff in the centre and with the wider management team.The person in charge was the manager of two services in the area and divided his time between both services. The person in charge was very focused on ensuring that a high standard of care and safety was being maintained. It was clear that the person in charge was very involved in the running of the service and that the residents knew him.

The provider had introduced a system to support staff when the person in charge was not on duty at weekends and during the night, whereby staff could contact a senior manager by telephone if advice was required. While this system supported staff with emergency advice, issues such as staffing shortage were addressed by the staff on duty, which impacted on the use of staff time to deliver care.There were, also, no formal arrangements in place to cover the ongoing daily role of the person in charge during absences such as annual leave. Therefore, during such absences, the staff on duty took on the responsibility for the running of the centre. Consequently some management functions were not being addressed until the person in charge returned from leave.

Staffing levels and skill-mixes were sufficient to meet the assessed needs of residents at the time of inspection, with nursing and care staff available to support residents. However, while there were adequate staffing levels on the day of inspection, the overall available staffing level was not sufficient to consistently fill the required roster from the existing staff pool. Agency staff were frequently required to fill the roster and the person in charge was sometimes required to work a nursing care shift to ensure that the required staffing levels could be met. This presented a risk that consistent staff may not always be available to support residents. When this occurred, it also reduced the capacity of the person in charge to complete governance duties.

A range of training modules had been provided for staff to enable them to carry out their roles effectively, although some of the training modules required by the provider had not been completed by some staff. A training needs analysis had been carried out to inform the training plan for the centre for 2022, and a matrix for tracking staff training had been developed. A review of the training matrix indicated that some of the provider's required training had not yet been completed by all staff. The failure to achieve this was attributed to the instability of Internet access in the area for online training, and also the inability to release staff for face-to-face training due to care and support commitments in the centre. However, the person in charge was mindful of this deficit and was working on a plan to achieve all staff training as required.

Overall, the centre was well resourced to ensure the effective delivery of care and support to residents, although improvements to household budget access required review to ensure that the required to ensure that household shopping could be carried out as required. Effective resources included the provision of suitable, safe, clean and comfortable living arrangements and dedicated transport for the centre. A range of healthcare professionals were available to support residents as required.

The centre was also supplied with a wide range of opportunities for residents to take part in activities that were very meaningful to them and that they enjoyed. These opportunities included a supply of materials, suitable work spaces, garden equipment and facilities to carry out their craft works. Furthermore, staff were based in the centre throughout the day which enabled residents to take part these activities that they enjoyed both in the centre an in the wider community. Nursing staff were also employed in the centre to oversee residents' healthcare requirements. However, financial resources for household shopping were managed by a central office which sometimes presented staff with difficulty in purchasing household shopping for the centre as it was required and there had been instances where the centre's transactions had been declined. This presented a risk that sufficient food supplies might not be available to residents. There was also a risk that staff may have to spend excessive time travelling longer distances to approved retail outlets to secure groceries for the centre, which impacted on the time available to spend in the care and support of residents.

Records were generally maintained in a clear and orderly fashion and were kept up to date. However, some improvement to the accessibility of records and the content of some healthcare records were required. While there was a detailed computerised personalised planning and assessment system in place in the service, it was the provider's practice that this system only accessible to nursing staff. Therefore, most staff did not have access to these records and information in this format. Records from the computerised system were being printed to provide information to these staff. On review it was found that the printed records were not easy to read and the information was not presented as clearly as in the computerised records. This presented a risk that some information might not be clearly accessible to all staff. Furthermore, some residents required food diaries and these were not recorded in sufficient detail to inform further assessment of these residents' nutritional needs.

## Regulation 15: Staffing

Staffing levels and skill-mixes were sufficient to meet the assessed needs of residents at the time of inspection. However, the provider had not been successful in ensuring sufficient staff to consistently fill the staff roster from the existing staff pool, which resulted in the ongoing use of agency staff and sometimes the person in charge to fill these roles. This presented a risk that consistent staff may not always be available, which could impact on continuity of care and support for residents.

The following improvement is required:

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

Judgment: Substantially compliant

## Regulation 16: Training and staff development

Some staff had not attended mandatory training and refresher training in line with the provider's training needs analysis.

The following improvement is required:

- ensure that staff attend all mandatory training required by the provider

Judgment: Substantially compliant

## Regulation 19: Directory of residents

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

Judgment: Compliant

## Regulation 21: Records

Overall, the provider had ensured that records were maintained in a clear and orderly fashion and were kept up to date. However, some residents required food diaries and these were not recorded in sufficient detail to inform further assessment of these residents' nutritional needs. Furthermore, while there was a detailed computerised personalised planning and assessment system in place in the service, some staff did not have access to this system. Records from the computerised system were being printed to provide this information to staff. On review it was found that the printed records were not easy to read and the information was not presented as clearly as in the computerised records. It was also found that most staff did not have access to computer technology as a means of sharing and receiving relevant information relating to their work.

The following improvement are required:

- ensure that records of nutritional management for individual residents are in sufficient detail to inform future assessments
- ensure that all staff have access to clear personal planning records to enable them to consistently deliver appropriate care and support to residents
- explore the option of information technology access for sharing information

with staff.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Overall there were improved leadership and management arrangements in place to govern the centre and to ensure the provision of a good quality and safe service to residents. However, there were some areas where improvements were required. The areas for improvement related largely to staff training, and support and deputising arrangements for the person in charge, consistent staffing, and access to adequate financial resources.

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

However, improvements were required in the following areas:

- ensure that consistency of staff and continuity of care is provided
- ensure that suitable deputising arrangements are put in place to cover the absence of the person in charge
- ensure that systems were in place to enable staff to attend required training in a timely manner
- ensure that all required staff training is carried out in line with the provider's training plan for the centre
- ensure that financial resources are appropriately managed to ensure that required grocery and household requirements can be sourced as required
- ensure that the required audits are carried out in line with the provider's audit plan
- explore the use and effectiveness of email and computerised systems as a means of sharing information and communication for all staff.

Judgment: Not compliant

## Quality and safety

Residents living at this centre received person-centred support and a good level of health and social care. The person in charge and staff were very focused on ensuring that residents' general welfare, social and leisure interests,and community involvement were well supported ,which enabled them to be involved in activities that they enjoyed.

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

The centre comprised one detached house in a coastal town with a variety of amenities and facilities in the surrounding areas. The location of the centre enabled residents to visit the shops, coffee shops and restaurants and other leisure amenities in the area, and to take part in community projects in the town. Transport and staff support was available to ensure that these could be freely accessed by residents. Some of the community based activities that residents enjoyed included visiting families, cinema, bowling, shopping, sports,swimming, going to a gym and going to concerts. While in the centre residents enjoyed gardening and growing fruit and vegetables, arts and crafts, food preparation and other independent living skills.

The centre suited the needs of the residents, and was spacious, warm, clean, comfortable and well maintained. The inspector found that the communal rooms were decorated in a homely manner with pictures and photos, and comfortable furniture. There was a well equipped kitchen and dining area which was central to life in the centre. All residents had their own bedrooms, and there were adequate bathrooms in the centre to meet the needs of residents. There were large gardens to both the front and rear of the building and residents enjoyed spending time on outdoor projects.

Comprehensive assessments of the health, personal and social care needs of each resident had been carried out, and individualised personal plans had been developed for residents based on their assessed needs. There were systems in place to support residents to achieve the best possible health. These included good access to a range of healthcare services, such as general practitioners, healthcare professionals and consultants. Nursing staff were also based in the centre for the ongoing review and assessment of residents' healthcare needs.

Residents' nutritional needs were well met and suitable foods were prepared to meet residents' needs and preferences. Nutritional assessments were being carried out and plans of care had been developed accordingly. Residents' weights were being monitored and support from dieticians and speech and language therapists was available as required. Residents, who chose to, were involved in food shopping and meal planning. Residents were very involved in preparation of their own meals with the support of staff.

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements relating to positive behavioural support at the

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

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

The provider had arrangements in place to safeguard residents from any form of harm. In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements relating to protection at the centre. At the time of inspection, the provider had commenced and completed 10 of the actions.

The actions completed by the provider included development of a safeguarding tracker, completion of a training needs analysis and development of a training schedule for staff. The development of a policy on the provision of safe Wi-Fi usage had not yet been achieved.

In the centre, there were good measures in place to safeguard residents from harm. However, while relevant training for both the person in charge and staff had commenced, it had not been completed for all staff. Safeguarding auditing also required improvement as some auditing was not being carried out in line with the provider's new auditing schedule. For example, staff safeguarding awareness auditing had not commenced at the time of inspection.

## Regulation 13: General welfare and development

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

Judgment: Compliant

## Regulation 17: Premises

The design and layout of the centre met the aims and objectives of the service, and the needs of residents. The centre was well maintained, clean and suitably decorated.

Judgment: Compliant

## Regulation 18: Food and nutrition

The resident's nutritional needs were being supported. The resident chose their own food. Suitable foods were provided to cater for the resident's preferences.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

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

Judgment: Compliant

## Regulation 6: Health care

The health needs of residents were assessed and they had good access to a range of healthcare services, such as general practitioners, healthcare professionals and consultants.

Judgment: Compliant

## Regulation 7: Positive behavioural support

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

In response to the targeted safeguarding inspection programme in January 2022, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements relating to positive behavioural support at the centre. At the time of the inspection, the inspector found that all seven actions had been suitably completed.

Additional multidisciplinary team supports had been recruited, were appointed, and available to residents as required, while one post which had been approved and recruited was not yet in position, but was due to take up the role shortly. Staff

training in managing behaviours of concern had been completed by all staff.

Judgment: Compliant

## Regulation 8: Protection

The provider had arrangements in place to safeguard residents from any form of harm. In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements relating to protection at the centre. At the time of inspection, the provider had commenced and completed 10 of the actions.

The actions completed by the provider included development of a safeguarding tracker, completion of a training needs analysis and development of a training schedule for staff. The development of a policy on the provision of safe Wi-Fi usage had not yet been achieved.

In the centre, there were good measures in place to safeguard residents from harm. However, while relevant training for both the person in charge and staff had commenced, it had not been completed for all staff. Safeguarding auditing also required improvement as some auditing was not being carried out in line with the provider's new auditing schedule. For example, staff safeguarding awareness auditing had not yet taken place but were due to commence in December.

In relation to the providers actions plan, the following improvements were required:

- ensure that a policy on safe Wi-Fi provision is provided
- ensure that all staff attend sexuality awareness training
- ensure that the person in charge is presented with the opportunity to attend training on preliminary screening
- ensure that staff safeguarding awareness auditing is carried out in line with the audit schedule for 2022.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Moville Residential Group Home OSV-0003339

## Inspection ID: MON-0034859

## Date of inspection: 16/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>To ensure compliance with Regulation 15: Staffing, the following actions has taken place<br><br>All Form B's to replace staff have been completed and returned to HR for completion and circulation to relevant panels<br><br>An Expression of Interest has been circulated by HR on the 03/01/2023 with a closing date of 10/01/2023<br><br>Currently staffing vacancies are being managed through the staffing compliment within Dunshenny House and familiar agency | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>To ensure compliance with Regulation 16: Training and Staff Development the following actions will be taken.<br><br>PIC has reviewed the training matrix completed 25/11/2022.<br><br>A training plan has been provided for each member of staff who will have completed all mandatory HSEland training and present certificates for updating of the training matrix by 15/01/2023. | |

All staff have completed CPR training 31/12/2022.

Schedules are in place for all other required face to face training to be completed by 30th April 2023.

| | |
|---|---|
| Regulation 21: Records | Substantially Compliant |

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

New food diaries from 1st January 2023 now contain a sufficient description of the nutritional intake of the residents.

The Care Note System is being reviewed by Senior Management with a view to converting to a more suitable recording system for resident information.

| | |
|---|---|
| Regulation 23: Governance and management | Not Compliant |

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

Currently staffing vacancies are being managed from staffing compliment within Dunshenny House and familiar agency

The most senior nurse in charge will deputise in the absence of the PIC with support from the ADON

A schedule of face to face training has been developed for all staff for completion by 30/04/2023

A review of the process for completing payment of invoices is currently being undertaken by Senior Management to ensure there are no issues going forward.

Current email and computerised systems in use are being reviewed by Senior Management to ensure effective communication for all staff members.

The provider has ensured that the centre is resourced to ensure the effective deliver of care and support in accordance with the statement of purpose since 31/01/2023 - 0034859

| | |
|---|---|
| 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

Policy on the Safe Use of the Internet for Service Users has been finalised on the 21/12/2022. Full implementation of this policy will be completed with all staff by the 31/01/23

Sexuality Awareness in Supported Setting training is currently scheduled for all staff in the area commencing on January 2023.

Safeguarding Awareness auditing for staff has commenced and will continue to be carried out in compliance with the CHO1 revised audit schedule in 2023.

PIC will complete Preliminary screening training and interactive webinar on HSEland

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 15(3) | The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | Substantially Compliant | Yellow | 10/01/2023 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Substantially Compliant | Yellow | 30/04/2023 |
| Regulation 21(1)(b) | The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are | Substantially Compliant | Yellow | 30/03/2023 |

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| | available for inspection by the chief inspector. | | | |
| Regulation 21(1)(c) | The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector. | Substantially Compliant | Yellow | 01/01/2023 |
| Regulation 23(1)(a) | The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. | Not Compliant | Orange | 31/01/2023 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Substantially Compliant | Yellow | 30/03/2023 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 31/01/2023 |
| Regulation 08(7) | The person in charge shall ensure that all staff receive appropriate | Substantially Compliant | Yellow | 31/01/2023 |

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| | training in relation to safeguarding residents and the prevention, detection and response to abuse. | | | |