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:	Dreenan Ard Greine Court
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Short Notice Announced
Date of inspection:	27 April 2021
Centre ID:	OSV-0005490
Fieldwork ID:	MON-0031393

About the designated centre

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

This centre consists of two houses Dreenan and the Glebe. Dreenan provides full-time residential care and support for up to six adults with a intellectual disability and the Glebe is another house used solely as an isolation house during the COVID-19 pandemic. It is situated outside the campus, but near Ard Greine Court and is registered under the governance of Dreenan. However, other centres in the Ard Greine Campus use this facility where isolation of a resident/residents is required. Dreenan comprises of a six bedroom bungalow and residents have access to communal facilities at the centre which include two sitting rooms, a dining room, a kitchenette, a laundry room and bathroom facilities and each resident has their own bedroom. The centre is located within a campus setting which contains a further three designated centres operated by the provider. It is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and cafes. Residents are supported by a staff team of both nurses and care assistants. During the day, residents are supported with their assessed needs by four staff members with one nurse being on duty at all times. At night-time, residents are supported by two staff, a nurse and health care assistant, with additional support being provided by a nurse in charge who is responsible for the entire campus.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 - 2015 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 27 April 2021	09:30hrs to 16:30hrs	Thelma O'Neill	Lead

What residents told us and what inspectors observed

Overall, the residents living in the centre were well cared for and they received the care and support required to meet their individual support needs. The inspector only visited Dreenan house on this inspection and met all of the residents and observed that four of the five residents had very complex medical care needs. Each of the residents required full assistance in all areas of care, including food and nutrition, personal hygiene, mobility, social care and safety.The remaining resident was more independent, mobile and vocal and had been living at home with their family until 2018.

The premise was found to be welcoming, with flower pots at the entrance, there was a hallway and sitting room directly inside the front door, three residents were relaxing in the sitting room and they appeared relaxed and comfortable in their comfort chairs. Staff were preparing to bring the residents out for a walk in their wheelchairs, and the inspector spoke briefly to the residents and staff. The inspector was shown around the centre and each of the residents had their own bedrooms (two en suite and four single) and there was a Jacuzzi in the main bathroom, which was wheelchair accessible. Their was one vacancy, in the centre, but this room was being used for a staff break room and for storing equipment. The inspector saw wheelchairs stored in the second sitting room as their was a lack of appropriate storage space in the centre. These were a hazard to residents who were at risk of falls.

The residents' meals were supplied twice a day from the centralised kitchen on the campus. Residents' notes showed the food supplied was specific to residents' individualised nutritional needs. For example, one resident was assessed as requiring a textured c pureed diet due to a choking risk, and this was supplied by the kitchen daily. Although the centralised kitchen closed at 4.30pm, it was note that staff had completed grocery shopping which included purchasing foods suitable for residents' individual likes and needs. This ensured additional food supplies were available in the centre to offer residents if they requested something extra in the evening. Improvements were required in the design and layout of the centre in terms of the kitchen, as it was too small for residents to access, due to residents being wheelchair users.

The inspector saw residents that required support with safe moving and handling had the appropriate assessments completed and equipment made available, and funding had been sanctioned by the provider; the Health Service Executive, for additional moving and handling equipment for one resident that was required in their bedroom. This equipment was scheduled to be installed in the centre in the coming weeks.

Residents also had timely access to health care professionals and the inspector saw evidence that residents' health care needs were attended to in a timely manner by the appropriate health care professionals. Although staff stated that a residents'

daily routines and social activities were significantly impacted upon by public health restrictions due to COVID-19, they tried to ensure residents had a daily activity available.

Although residents living in Dreenan had very complex medical needs that required specialised equipment, the residents' bedrooms were nicely decorated and individualised to reflect their individual preferences and assessed needs. Residents' bedrooms were decorated with personal photographs and ornaments. The residents appeared both relaxed and comfortable in the house and one resident was happy to show the inspector around their home.

The resident told the inspector he found the COVID-19 restrictions difficult, as his work programme had ceased. He said he hoped the pandemic would end soon so things could get back to normal and he could meet his friends and staff in day services. The inspector explained to the resident why she was visiting the centre and he told the inspector that he moved there in 2018 from home and it took a while to get used to, but he had now settled into the centre. He told the inspector about his bedroom door not closing properly and it was annoying him. The inspector asked to see his bedroom door and observed the door closures were stiff, resulting in the door staying half open. The inspector brought this to the attention of the person in charge and he arranged for maintenance to fix it immediately, this issue was rectified before the end of the inspection. The resident also told the inspector that he had a sore leg and demonstrated to the inspector how he found walking difficult and told the inspector he would like a walking aid to prevent him from falling again. The person in charge talked to the resident about his concern and reminded the resident he had been reviewed by the doctor for his sore leg, however he agreed to arrange a physiotherapist assessment for the resident post inspection. The inspector reviewed the resident's file and found the resident had been reviewed by his general practitioner, and that this issue was also included in the resident's behaviour support plan. The inspector was told this resident was not suitably placed in this centre and he would be better placed in another more active environment which would enhance the resident's quality of life. There was a plan to move the resident within the coming year to a more suitable environment.

The resident and the inspector went outside for a walk around the garden and he showed the inspector ornaments he had purchased and placed around the garden. He said he enjoyed looking at them while relaxing outside on the patio furniture. The inspector found the garden to be safe and although the external gates were locked for safety reasons, there were break glass units with the key in case of an emergency. There was ample space for the other residents who use wheelchairs to also sit outside in the patio area and enjoy the garden.

As well as a resident telling the inspector about activities they had enjoyed or were planned for the day, staff also spoke about activities the residents liked to do. Due to residents complex needs they did not access formal day placements and were supported by the centre’s staff with a bespoke day opportunity programme. Residents’ activities were planned in line with agreed care and support protocols which included ensuring residents who had epilepsy having staff with them that were trained to administer emergency medication. However, this was found to be an

issue that was limiting residents social activities, as only nurses were trained to administer the emergency medication to the residents. This was identified by the person in charge as limiting residents access to community and this had been escalated to the disability manager as a rights issue. The provider had recently taken measures to put a plan in place to train all health care staff to administer emergency medication to promote residents access to the community.

The inspector reviewed the staff rosters in the centre and the records showed that staffing had recently been increased in response to the needs of one resident who was a high falls risk. While this was found to be a positive measure for this resident, this had resulted in a high number of agency staff working in the centre, and this put extra pressure on regular staff to constantly induct new staff daily on the resident's individual needs. Furthermore, the inspector reviewed the staff rotas, and saw six of the regular staff including two nursing staff were transferred to work in other centres in the campus, resulting in 12 additional relief staff working in this centre. However, the person in charge told the inspector that as part of recent improvements at the campus, they were given responsibility to manage their own staff teams and rosters to minimise the staff changeover between centres and to improve the continuity of care for the residents.

Through reviews of documentation, observations and speaking with staff, it was evident that the person in charge and staff team at the centre were continually striving to ensure that the care and support provided to residents was person-centred in nature and effective in meeting their needs, although some improvements were required in relation to personal planning and the premises which will be described later in their report.

Capacity and capability

The provider had good governance and management arrangements in place to ensure effective oversight of this service. The provider had recently implemented a management improvement plan for the campus and although some of these actions were not completed, the inspector saw evidence that the provider had already strengthened its oversight of this service.

The centre was located on a campus with four other designated centres. The oversight and management was monitored by the acting director of services and the day to day management of the centre was overseen by a full-time and suitably qualified person in charge who was new in post, but demonstrated his active involvement in the centre. The person in charge was a registered nurse for people with disabilities and mental health and he had the skills and management experience required to assess, plan and implement individualised residents needs and ensure residents had good quality of care provided. The person in charge told the inspector that the provider had made the decision following previous inspections on the campus to appoint a clinical nurse manger 1 to each of the centres. This

would strengthen the overall governance and management of the centres.

Staff told the inspector that they had good support and supervision from the manager and any concerns or issues requiring clarification they could go to directly to the person in charge as he was based in the centre. A range of management audits including health & safety, fire safety, infection control, and accidents & incidents were completed by the person in charge. Where areas for improvement had been identified, clear action plans showing both the person responsible for agreed actions and timelines for achievement were in place. One such issue included the need for heath care assistants to be trained in administering emergency medication. There was some staff training outstanding in the centre, such as positive behaviour support, safe moving and handling, CPR, however, the person in charge had arranged or was in the process of arranging all outstanding training to be completed.

The monitoring of the care and support provided was further reinforced through the provider quality assurance audits as described in the regulations. The provider undertook six monthly unannounced visits to the centre as well as an annual review into the care and support provided. Both the visit and review were completed by a delegated member of senior management and provided assurances that residents' needs were being met at the centre. Where actions were identified, the provider had implemented a quality improvement plan that was regularly monitored. However, the provider did not ensure that they had adequately implemented a plan to address the hazards identified due to the lack of storage space for equipment in the centre, also the provider did not ensure safeguarding concerns were effectively reviewed and recommendations implemented in a timely manner.

As stated earlier in this report, appropriate numbers of suitably qualified staff were engaged at the centre to meet residents' needs. However, there was a need for a consistent staff team in the centre. Changes in staffing levels recently to reflect the needs of one resident had ensured their needs were met, and allow increased opportunities for community activities for the other resident at the centre with positive results.

Discussions with staff during the inspection, clearly evidenced that they were both knowledgeable of the residents and their needs and residents were supported in line with agreed plans, and how their individual interests and preferences were promoted on a daily basis. Staff knowledge was further reinforced through them having regular access to training, with reviewed records showing that all staff having completed most of the provider's mandatory training requirements, however, staff training was required by all staff on positive behaviour support, and the administration of emergency medication and additional safeguarding training.

Regulation 15: Staffing

The inspector found there continued to be frequent redeployment of staff to other designated centres, and agency staff working in the centre, which affected the

continuity of care for the residents.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider did not ensure that they had adequately implemented a plan to address the hazards identified due to the lack of storage space for equipment in the centre, also staff training was outstanding and the provider did not ensure safeguarding concerns were effectively reviewed and recommendations implemented in a timely manner.

Judgment: Substantially compliant

Quality and safety

Residents at Dreenan received good care and support which reflected both their assessed needs, care and support strategies, likes and preferences. Practices at the centre had led to positive and consistent improvements in the management of both residents' challenging behaviours and safeguarding concerns. Staff were supporting residents in line with their wished to make decisions about their daily lives. However, improvements were required in implementing safeguarding recommendations, the accessibility of the premises and institutional practices continued to impacted negatively around residents' rights and choices.

Although the current safeguarding risks in the centre were well managed, there was potential safeguarding risks to four residents who were living with one resident that that had previously display behaviours of concern in the centre. These residents were vulnerable and could not protect themselves in the event of an outburst in the centre, and did not have safeguarding plans in place to ensure all staff including relief staff were aware of this safeguarding risk. Furthermore, the inspector saw that there were safeguarding preliminary screenings open since 2019 for two residents in the centre, and despite significant safeguarding concerns being reported, it was not clear what was the current status of the risks posed to residents, and there was no details in the preliminary screening document stating if the provider had implemented the actions recommended from a safeguarding review of the incidents. A provider representative confirmed to the inspector that this issue was no longer a concern in the centre, and although some actions were complete, other actions had not yet been completed. Consequently following the inspection, a provider assurance report was sought from the provider seeking additional information on the safeguarding review and progress in relation to its recommendations.

Personal planning arrangements were in place for all residents at the centre, with reviewed personal plans being very comprehensive in nature and reflected both observed practices and discussions with staff. Care plans were structured with clear guidance for staff on all aspects of residents' needs which ensured a consistency of approach. Where changes or multi-disciplinary recommendations had been made on the care provided, these were reflected in amended parts of the plans especially in relation to the management of behaviour. Residents had been supported to identify goals they wished to achieve in the year including going to see wild life park, to improve physical health and maintaining family contact. Records showed that progression with these goals were regularly monitored by staff to promote their achievement.

The management of challenging behaviour was subject to regular multi-disciplinary team (MDT) reviews and behaviour support plans were updated where applicable. Reviewed behaviour support plans and support protocols were comprehensive in content and clearly guided staff on supports required, both from a proactive and reactive standpoint, and ensured a consistency in approach for residents. Where behavioural supports warranted the need for a recommended restrictive practice, this was reviewed by the multi-disciplinary team. Restrictive practices in use at the centre were regularly reviewed and were they only used the least restrictive option in line with the assessed need.

The provider's risks management procedures had recently being reviewed and the inspector found there was effective oversight of the risks in the centre. The person in charge had been effective in escalating risks to the provider and received timely responses to these risks. For example, one resident who was a high risk of falls had additional staff support provided following appropriate escalation of the risks. In addition, risk management arrangements at the centre were comprehensive in light of the assessed needs of the residents and clearly guided staff on agreed practices at the centre. Each resident had individual risk assessments completed and the centre had a organisational risk register maintained which identified centre specific risks.

A review of fire safety procedures in the centre showed there were effective measures in place to prevent, control and manage the risk of fire in this centre. The inspector saw evidence that the provider had measures in place to check fire equipment regularly, and personal evacuations plans were in place to identify how to evacuate the residents in the event of a fire. The person in charge had completed regular fire drills and records showed the centre could be evacuated in a timely manner. The person in charge had address the issue during the inspection where the fire door closure had got stuck in a residents bedroom and had caused some concern to the resident.

In response to the global pandemic, enhanced arrangements had been implemented to manage the risk of a possible outbreak of COVID-19 at the centre. Infection control procedures to manage COVID-19 included visitors and staff completing self-assessments on current symptoms, and compliance with agreed infection control procedures at the centre and enhanced cleaning arrangements were in place. Furthermore, on arrival at the centre, the inspectors temperature was checked and

staff informed them that this occurred for all staff and visitors on arrival at the centre to ensure they were not displaying any of the known symptoms of COVID-19, and therefore present a risk to the residents. The inspector also observed that all staff wore face masks during the day and supplies of both PPE and alcohol sanitizer were readily available throughout the centre along with key information on how to recognise the symptoms of COVID-19 and prevent the spread of the virus.

Regulation 17: Premises

The design and layout of the premise was not accessible for residents who were wheelchair users. There was also a lack of storage space in the centre to store wheelchairs and equipment. However the provider had submitted a improvement plan for the campus to address these issues, but the action was still in progress and not complete.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had effective oversight of the risks in the centre. The person in charge had been effective in escalating risks to the provider and received timely responses to these risks. For example, one resident who was a high risk of falls had additional staff support provided following appropriate escalation of the risks. Each resident had individual risk assessments completed and the centre had a organisational risk register maintained which identified centre specific risks.

Judgment: Compliant

Regulation 27: Protection against infection

Infection control practices at the centre were comprehensive in nature and had been enhanced in light of the provider's COVID-19 policies and the implementation of public health restrictions. Staff had received COVID-19 related training and had easy access to both PPE and alcohol sanitizer supplies at the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety procedures in the centre showed there were effective measures in place to prevent, control and manage the risk of fire in this centre. There were measures in place to check fire equipment regularly, and personal evacuations plans were in place in the centre to identify how to evacuate the residents in the event of a fire. There were regular fire drills and records showed the centre could be evacuated in a timely manner. The person in charge had address the issue during the inspection where the fire door closure had got stuck in a resident's bedroom and had caused some concern to the resident.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents individual assessments were found to be comprehensive and nursing interventions were well documented and kept up to-date. Residents personal plans for social activities were also in place and there was clear evidence of person centred planning (PCP) meetings with the residents and actions plans with timely goals set to achieve over the summer.

Judgment: Compliant

Regulation 6: Health care

There was good evidence of residents with acute and complex medical needs having access to multi-disciplinary reviews and supports. Recommendations by the Multi-disciplinary Team, such as physiotherapist, and occupational therapist were being implemented, for example the recommendation for manual handling equipment to be installed was being implemented.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents that displayed behaviours of concern had behaviour support plans in place that were up to-date and regularly reviewed. However, staff required training in positive behaviour support, and the training was scheduled to be completed by July.

There were also restrictive practices in place in the centre, however, some had recently being reduced, and the person in charge told the inspector that these practices was constantly under review.

Judgment: Compliant

Regulation 8: Protection

Although current safeguarding risks in the centre were well controlled, safeguarding risks posed to four vulnerable residents due to the behaviours of concern previously displayed by one of their peers were not documented in safeguarding plans. In addition, Preliminary screenings open since 2019 had not been updated to reflect the current risk to two residents at the centre, and associated recommendations from an independent safeguarding investigation had not been fully implemented.

Judgment: Not compliant

Regulation 9: Residents' rights

This centre is part of a congregated setting and institutional practices impacted negatively around residents rights and choice, for example, access to their personal money, and choices of food were restricted as meals were provided from a centralised kitchen. The provider had recently taken action to address some of these issues, as they had been identified as campus wide issues, and was implementing a plan to address some of these institutional practices.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Dreenan Ard Greine Court OSV-0005490

Inspection ID: MON-0031393

Date of inspection: 27/04/2021

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: In order to bring this Centre into compliance the following actions will be taken: 1) Each Centre has an identified and dedicated staffing cohort allocated. The Person in Charge is completing the roster for the Centre from the staffing cohort. Staff from the Centre's staffing cohort is being used for cover purposes. Completed 26.04.2021 2) The Director of Nursing and the Provider Representative have designed a standalone roster for the Centre to provide a dedicated and consistent staff team. Completed 19.04.2021 3) The Director of Nursing, Provider Representative and the Human Resource department have consulted and engaged with staff representative bodies regarding the implementation of a new roster. Engagement commenced on 30.04.2021 and the new revised roster will be in place by the 31.07.2021.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to bring this Centre into compliance the following actions will be taken: 1) A risk assessment has been completed by the Person in Charge regarding equipment storage issues with the centre. Alternative arrangements have been put in place which has been communicated to all staff working within the Centre. 2) The Person in charge has requested a full review of all current seating and moving and handling equipment by the Occupational therapist to assess the need for existing	

equipment, this will be completed by 14.06.2021.
3) An additional tracking hoist system will be installed in one resident's bedroom by 25.06.2021.
4) A full review of staff training has been completed by the PIC on the 27.05.2021. Dates have been scheduled for outstanding training. 2 staff who were outstanding in moving and handling training completed this 07.05.2021, and training scheduled for staff outstanding in the areas of positive behavior support will be completed by the 30.06.2021. Outstanding CPR training for staff will be scheduled once this training has commenced once covid-19 restrictions have been lifted.
5) The policy on supporting Sexuality in Supported settings for Adults who have an intellectual Disability will be rolled out in Dreenan Centre. Policy implementation will be supported by the delivery of sexuality awareness in supported settings training, the training will be delivered via an interactive virtual platform. Completion date: 31.08.2021.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to bring this Centre into compliance the following steps have/will be taken:

1. A risk assessment has been completed by the Person in Charge regarding equipment storage issues with the centre. Alternative arrangements have been put in place which has been communicated to all staff working within the Centre.
2. The Person in charge has requested a full review of all current seating and moving and handling equipment by the Occupational therapist to assess the need for existing equipment, this will be completed by 14.06.2021.
3. An additional tracking hoist system will be installed in one resident's bedroom by 25.06.2021.
4. HSE Estates will carry out a preliminary review of the design and layout of the centre's kitchenette, utility and dining area and develop options to reconfigure the centre to ensure it meets the aims and objectives of the service and promotes the full capabilities and independence of residents in choosing, preparing and cooking meals of their choice. The Disability Services Manager as Provider Representative and the Director of Nursing will engage with the Housing Association to discuss and gain agreement on proposed options to adapt the layout of the centre further to review by Estates. This will be completed by 30.06.2021
5. In the interim the dining room within the Centre will be available to facilitate wheelchair users ease of access to activities such as cooking baking etc.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: 1) A robust overarching safeguarding plan has been developed and implemented for each resident. A revised process has been put in place in conjunction with the CHO1 Safeguarding & Protection team to strengthen processes in respect of the provision of supports and recommendations within the plans. 2) The policy on supporting Sexuality in Supported settings for Adults who have an intellectual Disability will be rolled out in Dreenan Centre. Policy implementation will be supported by the delivery of sexuality awareness in supported settings training. Completion date: 31.08.2021.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: In order to bring this Centre into Compliance the following steps will / has be taken: 1. Each resident is supported to hold a cash balance of €50 for day to day expenditure. 2. Residents are supported by staff to access personal monies from their PPP accounts, including at short notice if required. 3. A quarterly financial statement is provided to each resident. 4. A Financial Competency Assessment and Evaluation is completed for each resident. 5. One resident has commenced a skill building programme to promote independence in the area of money management. 6. Residents continue to be supported by staff to prepare simple meals and baking in the Centre should they wish to do so. There remains a fully accessible kitchenette within the Centre. 7. Breakfast continues to be prepared in the Centre and there is a wide range of options available based on individuals preferences. 8. All Meals are provided taking into account individual preferences and assessed needs. (SALT assessment and dietetic recommendations) 9. Dinner and evening meals continue to be provided from a kitchen separate to the Centre. There is a choice of two hot meals as well as soup and salads. Meals are prepared by qualified chefs. 10. A weekly shopping list is compiled by the Nurse in charge in collaboration with the residents as discussed at the weekly residents meetings, (usually Saturday morning's). This list comprises the food ingredients to offer alternative meals for residents not wishing to avail of the meals which are prepared in the separate kitchen to the Centre. 11. Residents will be supported by staff to prepare simple meals in the Centre if they wish to do so to facilitate residents with an alternative meal option in line with their will	

and preference. A range of alternative meals will be consistently available in the Centre:

12. HSE Estates will carry out a preliminary review of the design and layout of the centre's kitchenette, utility and dining area and develop options to reconfigure the centre to ensure it meets the aims and objectives of the service and promotes the full capabilities and independence of residents in choosing, preparing and cooking meals of their choice. The Disability Services Manager as Provider Representative and the Director of Nursing will engage with the Housing Association to discuss and gain agreement on proposed options to adapt the layout of the centre further to review by Estates. This will be completed by 30.06.2021

13. In the interim the dining room within the Centre will be available to facilitate wheelchair users ease of access to activities such as cooking baking etc.

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	31/07/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre	Substantially Compliant	Yellow	30/06/2021

	to ensure it is accessible to all.			
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	31/08/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/08/2021
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	30/06/2021