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:	St Anne's - Naomh Áine's
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	16 January 2023
Centre ID:	OSV-0007235
Fieldwork ID:	MON-0038694

About the designated centre

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

Naomh Aine's provides full time residential care for four male and female residents who are over the age of 18 years and who have a diagnosis of moderate intellectual disability. The service supports varying care needs including support with mental ill health, dietary needs, medical needs, visual impairment, behaviours of concern, and care associated with ageing. The staff team consists of named nurses and health care assistants. There is an waking night staff arrangement in place. The centre is a detached house in a rural, coastal area, and there is transport provided for residents to access the amenities in their locality.

The following information outlines some additional data on this centre.

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
Monday 16 January 2023	09:00hrs to 16:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which was carried out following the receipt of information from the provider in the form of monitoring notifications. The purpose of this inspection was to assess the safety of the service provided and the quality of the care and support provided to the residents. Furthermore, to monitor the provider's ability to adhere to the actions agreed following the issuing of a provider assurance report in September 2022.

St Anne's – Naomh Áine's is located in a scenic coastal location in a rural area. It is within driving distance of a small town where there are shops, hairdressers and other community amenities. The property provided is a spacious two story house, which was homely and welcoming. There was a shared kitchen and dining room, with a comfortable sitting room nearby. The doors of the sitting area opened out to paved area for residents' use during the summer months. Each resident had their own bedroom. The female residents had a shared accessible bathroom, while the male residents had en-suites provided. This arrangement was reported to be working well. Three residents invited the inspector to see their rooms. The inspector found that they were well presented and decorated nicely. Overall, this property provided a comfortable living space for the residents living there.

On arrival at the designated centre, the inspector met with all four residents. One resident was getting ready to attend their day service. They spoke briefly with the inspector about their family members and about a gift that they received for Christmas. A second resident was sitting at the table having tea. The staff on duty told the inspector that the resident felt concerned about the winter weather and were not going to their day service on that day. This resident spoke with the inspector about the staff on duty, about their family and about a party that they were looking forward to. The third resident was observed finishing their breakfast and going to their room to get ready for the day. Another resident was having a sleep in. This resident had very good communication skills and the inspector spoke with them later that day. They said that they were happy living at St Anne's – Naomh Áine's and that it was a lovely home. However, they told the inspector that when one resident became upset that they shouted loudly. They said that they did not like it and that it was not nice. When asked what they would do if that happened; they told the inspector that they would stay in their room.

During the time of inspection the three residents that remained at home were observed moving around the house and participating in activities of their choice. These included having tea and chatting with staff, looking at photographs and magazines and doing some colouring which they said that they enjoyed. Another resident spent time in their room where they were observed organising their personal items while listening to music.

Throughout the day of inspection, the inspector met and spoke with five members of staff on duty. They told the inspector that they were employed as healthcare

assistants. There was no nurse on duty that day and staff told the inspector that if a matter required escalation, then they were required to call another designated centre. This was located in a different part of the same town. These conversations will be expanded on later in this report.

In general, the inspector found that this designated centre provided a comfortable home for the residents that lived there. However, the inspector found that the governance and management arrangements in place required review to ensure that they were effective. Furthermore, from the observations made, information reviewed and conversations held, the inspector found that the day to day lived experiences of the residents was significantly impacted by the behaviours of concern that were ongoing in this centre. For example, they were choosing to spend time in their rooms where they would eat their meals if this was required. This meant that they were excluded from parts of their home. Furthermore, the inspector found that when an incident occurred, the residents were telling the staff on duty that they felt sad and that they felt afraid. This will be expanded on later in this report.

The following two sections of the report will expand on how the lack of effective governance and management was negatively impacting on the quality and safety of the lives of residents living in this centre.

Capacity and capability

As outlined above, this inspection was carried out following the receipt of information from the provider in the form of monitoring notifications and to monitor the quality and safety of the service provided. The inspector found that although there was a good organisational structure in place, the governance arrangements were remote in nature. Therefore the staff team at St Anne's – Naomh Áine's did not have direct support when required. Furthermore, improvements were required with the staffing arrangements in place, the implementation of positive behaviour support plans, safeguarding of residents, complaints, risk management and residents rights.

The provider had prepared a statement of purpose which was recently reviewed and updated. It was available in the centre and contained the information required under Schedule 1 of the regulations.

A review of policies and procedures as required under Schedule 5 of the regulations was completed. They were reviewed recently, were available in writing and were up to date. This was an action agreed with the provider following on from the July 2022 inspection.

Staff had access to training, including refresher training, as part of a continuous professional development programme. There was a training matrix in place which was reviewed and updated as required. The inspector viewed a sample of training modules and found that they were completed in full and were up to date. In addition, staff had access to a programme of formal supervision and all meetings

were completed to date.

The staff roster was reviewed and in the main it was found to provide an accurate reflection of the staff that were on duty on the day of inspection. However, as previously referred to, there no nursing role documented on the roster. If required the staff on duty were required to call the nurse in another centre to report incidents occurring or to seek advice. This was not in line with the statement of purpose provided and the arrangements in place were not effective. In addition, the inspector viewed a sample roster of weekend and holiday periods. There was some evidence of additional 1:1 staff support at weekends as recommended in order to support residents with behaviours of concern and to safeguard and protect others from abuse. Staff on duty said that when additional support was in place that it was very effective. However, the inspector found that the 1:1 additional staff as recommended as part of a behaviour support plan was not documented on the roster and was not happening.

With regard to holiday periods, the inspector reviewed a recent fourteen day period when all residents were at the designated centre. On twelve out of fourteen occasions, there was no 1:1 support available during the daytime. Staff spoken with told the inspector about the risks associated with a reduction in staff members and that this had a significant impact on the residents' quiet enjoyment of their home.

A review of the governance and management arrangements in place found that the provider failed to ensure that the designated centre was resourced to ensure the safe and effective delivery of care and support for the residents. As stated, there was a defined management structure with clear lines of authority, however, this was not working at the time of inspection. For example, an agreed remote working arrangement was in place for the person in charge. They told the inspector that they were available by telephone but were rarely at the designated centre. Secondly, nursing staff were not employed which was contrary to the requirements of the statement of purpose. This meant that nursing notes and nursing care plans were updated at another location. If advice, support and feedback was required, in the main, this was provided by telephone. A review of the documents in relation to the care and support of residents was completed. The person in charge told the inspector that the annual review of care and support was updated recently and therefore not available at the time of inspection. The six-monthly provider led audit had a date agreed. Therefore, it was not an unannounced visit as required under regulation 23. Also, other documents in relation to the care and support of the residents lacked clarity and in some cases they were not available or held at another location. Team governance meetings were taking place but not in accordance with the provider's policy. For example, the most recent meeting minutes available at the centre were dated June 2022. An additional meeting took place in September 2022, however this was resident specific. These communication systems required review.

In addition and as outlined under regulation 15, recommendations in relation to additional staffing ratios required were not fully actioned. These recommendations were made by members of the multi-disciplinary team. In addition, they were documented on risk assessments, in residents' safeguarding and protection plans and were included in the provider assurance report issued in September 2022. It

was clear that there were significant concerns in relation to safeguarding and protection of residents and the compatibility of residents living at this centre. However, the person in charge told the inspector that they did not have access to a suitable compatibility assessment tool and no compatibility assessments had taken place.

In addition, a review of complaints process used in the centre was completed. This was due to the fact that residents were expressing their concerns and distress in relation to behaviours of concern that were on going. The inspector found that when this happened, the staff on duty handled matters with care and compassion. However, although an updated complaints policy was circulated in November 2022, it was not available at the centre. Therefore, there was no arrangement in place to ensure that the voice of the resident was acknowledged, recorded or addressed under the provider's complaints policy. This required review.

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

Regulation 15: Staffing

The provider failed to ensure that the number, qualifications and skill mix of staff was appropriate to the statement of purpose and the assessed needs of the residents. The following areas required improvement;

- The provision of nursing care in line with the residents assessed needs and in accordance with the statement of purpose
- The provision of additional staff to support a resident with behaviours of concern as recommended by the multi-disciplinary team and in line with safeguarding plans

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to training, including refresher training, as part of a continuous professional development programme. There was a training matrix in place which was reviewed and updated as required. In addition, staff had access to a programme of formal supervision which was up to date.

Judgment: Compliant

Regulation 23: Governance and management

This centre was not adequately resourced to ensure that residents were provided with a safe and quality service. Although there was a defined management structure and a clear line of authority in place, this was not working well at the time of inspection. The following areas required improvement;

- The provision of suitable staffing arrangements in line with recommendations of the multi-disciplinary team, the safeguarding plans and the requirements of the statement of purpose
- The arrangements in place to ensure that the person in charge was available in the designated centre on a regular basis, that team meetings were held in line with the providers policy and that the minutes were available for review
- The systems in place to ensure that a suitable compatibility tool was in place and that assessments were completed as required
- The arrangements in place to ensure that documents in relation to the care, support and welfare of the residents were available for review in the designated centre
- The procedures in place to ensure that concerns raised by residents were acknowledged, recorded and addressed in line with the providers complaints policy
- The arrangements in place to ensure that provider-led six monthly audit was up to date and that this was an unannounced audit

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which was reviewed regularly and met with the requirements of Schedule 1 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider failed to ensure that an effective complaints procedure was available in the designated centre and that it was displayed in a prominent position. The following areas required improvement;

- The arrangements in place to ensure that the most up-to-date policy is available and in use in the designated centre
- The arrangements in place to ensure that all complaints are acknowledged as

such and investigated promptly

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had policies and procedures in place which were prepared in writing, available to staff and were in line with the requirements of Schedule 5 of the regulations.

Judgment: Compliant

Quality and safety

In general, the residents living at this designated centre received a good level of care and support from the staff on duty. They were facilitated to attend appointments with their general practitioner (GP) and had access to members of the multi-disciplinary team. However, the inspector found that the increase in the number of safeguarding incidents occurring had a significant impact on the day to day lived experience of residents living at the centre. The inspector was not assured that the residents were adequately safeguarded and protected.

Residents that required support with behaviours of concern had support plans in place and staff spoken with told the inspector that they had training in positive behaviour support. There was evidence of multi-disciplinary involvement with regular and ongoing meetings with a consultant psychiatrist, a clinical psychologist and a clinical nurse specialist (CNS) in positive behavioural support. Although the resident had a positive behaviour support plan it was not kept on their personal file and therefore was not available in the centre. However, a copy was located later in the afternoon. The inspector found that this plan advised the completion of a recording process which would identified antecedents, behaviours and consequences. The person in charge was unsure if these were being completed. As previously stated there was a clear recommendation that 1:1 support was required in order to support the resident and that this staffing arrangement should rotate in order to prevent an over reliance on individual staff members. The inspector found that this was not fully actioned in line with the recommendations made. This required review.

The inspector found that the provider had not ensured that residents were protected from abuse and responsive measures had not been taken to address ongoing safeguarding issues in the centre. The provider had a local safeguarding and protection policy in place. However, this required updating to ensure it was effective

as the designated officer shown on posters displayed was no longer working in the service. The safeguarding and protection plans for the service were reviewed and cross referenced with the progress notes held in the centre. The inspector found that although a safeguarding and protection process was in place it was not always followed through. For example, one safeguarding form showed that a resident said that they were afraid of their peer as they were called names and blamed for things that they did not do. They would go to their room and request to have their meals there if required. The inspector found that the preliminary screening form and safeguarding plan was completed (PSF1). It was submitted to the safeguarding and protection team who responded with a preliminary screening outcome sheet (PSF2). However, the person in charge told the inspector that although the third stage of the process was completed (PSF3); the information was not available for review in the centre on the day of inspection. This showed that the process was not completed in full and therefore not effective.

In addition from the sample reviewed, another resident was called names and told that they were 'bold' on 3 occasions over a 3 week period. The staff on duty documented that when this happened that the resident began to cry and would go to their room.

A third resident spoke with the inspector. They said that when incidents occurred that she did not like it, that it was not fair and that she would stay in her room.

The inspector reviewed these incidents with staff who said that they would report these incidents to the nurse on duty in another centre. They told the inspector that they required more support and that they were concerned for the residents impacted as these incidents were very distressing for them. They said that they felt worried that residents were choosing to isolate themselves in their rooms or that they would go to the garden. It was clear that this impacted on the residents' human rights, their freedom to use all areas of their home and their quiet enjoyment of their living space.

There were systems and procedures in place for risk assessment and risk management. Risks impacting on residents were rated and escalated by the person in charge. These included a risk assessment on impact of self-injurious behaviour and the risks associated with safeguarding concerns. The control measures in place documented recommendations for 1:1 support from the multi-disciplinary team as previously outlined in this report. Furthermore, the assessments documented that when this support was in place that there was a reduction in the risk likelihood. The inspector found that improvements were required with the arrangements in place to ensure that there was ongoing review of risks identified and that the assessments were effective. Also, to ensure that risk control measures were actioned, were proportional to the risk identified and that any adverse impact such measures might have on the residents' quality of life were considered

Regulation 26: Risk management procedures

The provider had some systems in place for the assessment and management of risk, however, the following required improvement;

- To ensure that the systems in place for the ongoing review of risk are effective
- To ensure that risk control measures are proportional to the risk identified and that any adverse impact such measures might have on the residents' quality of life have been considered

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector was not assured that the systems in place to support residents with behaviours of concern were effective. The following areas required improvement;

- The arrangements in place to ensure that positive behaviour support plans designed to guide staff were available for review on the residents file
- That the recommendations of the multidisciplinary team in relation to staff support were actioned effectively
- The arrangements in place to ensure that staff were effectively supported in the designated centre by both nursing staff and the person in charge and that there were no remote governance arrangements in place

Judgment: Not compliant

Regulation 8: Protection

The provider had not ensured that residents were protected from abuse and responsive measures had not been taken by the provider to address ongoing safeguarding issues in the centre. The following areas required improvement;

- To ensure that all staff are aware of the identity of the designated officer and that the information provided in this regard is correct
- That the recommendations made in relation to safeguarding residents are actioned

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had arrangements in place to ensure that residents' had opportunities to participate in decisions about their care and support. However, significant concerns in relation to governance, management and safeguarding at this centre impacted on the residents' freedom to use all areas of their home and their quiet enjoyment of their living space.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Anne's - Naomh Áine's OSV-0007235

Inspection ID: MON-0038694

Date of inspection: 16/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with regulation 15 the following has actions have been under taken: • The Person in Charge has completed a further review of the staffing requirements to meet the assessed needs of the residents and the recommendation from the Multidisciplinary Team. Completion Date: 03-02-2023 • The Person in Charge has prepared and submitted an updated business case for additional staff to support the changing needs of residents within the Designated Centre. In the interim regular agency staff and dayservice staff will support this designated centre. Completion Date: 30-06-2023 • Nursing support is now clearly reflected on the roster in line with the centres Statement of Purpose. Completion Date: 03-02-2023 • The Person in Charge is now rostered and present a minimum 2-3 day a week in Naomh Aine and will be available on phone as required.Completion Date: 03-02-2023 • The Donegal Disability Services Out of hours on call support is available to staff from 1700-0900hrs, weekends and public holidays.	
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 the following has actions have been undertaken:	

• The Person in Charge has completed a further review of the staffing requirements to meet the assessed needs of the residents and the recommendation from the Multidisciplinary team. Completion Date: 03-02-2023
• The Person in Charge has prepared and submitted an updated business case for additional staff to support the changing needs of residents within the Designated Centre. In the interim regular agency staff and dayservice staff will support this designated centre. Completion Date: 30-06-2023
• Staffing requirements will be kept under continious review by the Assistant Director of Nursing and Person in Charge.
• Nursing support is now clearly reflected on the roster in line with the Statement of Purpose. Completion Date: 03-02-2023
• The Person in Charge is now rostered and present a minimum 2-3 day a week in Naomh Aine and will be available on phone as required. Completion Date: 03-02-2023
• The Donegal Disability Services Out of hours on call support is available to staff from 1700-0900hrs, weekends and public holidays.
• Governance staff meetings for this centre are scheduled bi monthly.
• Governance staff meetings were held on the 16-11-2023, 27-01-2023 with the next meeting scheduled for the 03-04-2023.
• Minutes of governance staff meeting are retained on file and these are made available to all staff.
• Meeting of the 27-01-2023 was arranged specifically to discuss the outcome of the inspection held on the 16-01-2023.
• Compatability assessments were completed in 2019 prior to each residents admission to the Designated Centre in December 2019. These are now available within each residents careplan. The changing needs of each resident will be continiously monitored in terms of compatability with the resident group. Completion Date: 03-02-2023
• All complaints and concerns raised by residents have been addressed recorded. Retrospective complaints have been completed for complaints recorded. Completion Date:03-02-2023
• The Donegal Disability Services recently reviewed Policy on the Management of Feedback (Complaints, Complements and Comments) is now available within this Designated Centre. Complaints easy read material has been made available to all residents. Completion Date:03-02-2023
• This reviewed policy was discussed at staff meeting held on the 27-01-2023 and will be discussed at the next staff governance meeting. Completion Date: 03-02-2023
• Weekly Residents meetings continue. Easy read material on Consent, Human Rights and Complaints are on the agenda and will be discussed at the next residents meeting. Completion Date: 03-02-2023
• The provider nominee will ensure that six monthly unanounced visits will be carried out withi the centre. Completion Date: 03-01-2023
• The Regional Director of Nursing has carried out an on site visit on the 7th February to provide guidance and support in relation to a number of issues identified.
• The Centres Quality improvement plan will be monitored on a weekly basis by the Assistant Director of Nursing, Regional Director of nursng and the General Manager Disability Services. Completion Date:11-02-23
• Regular oversight is provided by the Assistant Director of Nursing and the the Person in charge
The Assistant Director of Nursing meets with the person in charge bi monthly.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
To ensure compliance with regulation 34 the following has actions have been undertaken:

• All complaints and concerns raised by residents have been recorded and addressed. Retrospective complaints has been completed for complaints recorded Completion Date: 03-02-2023
• The Donegal Disability Services recently reviewed Policy on the Management of Feedback (Complaints, Complements and Comments) is now available within this Designated Centre. Complaints easy read material has been made available to all residents. Completion Date:03-02-2023
• The reviewed policy has been read and signed by staff, this was discussed at staff meeting held on the 27-01-2023 and will be discussed at the next staff governance meeting. Completion Date: 03-02-2023
• Weekly Residents meetings continue. Easy read material on Consent and Human Rights and Complaints are on the agenda and will be discussed at the next residents meeting Completion Date: 03-02-2023
• Staff will complete refresher training on complaints on HSELand Completion Date: 28/02/2023.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure compliance with regulation 26 the following has actions have been taken:

• One residents Risk Assessment has been reviewed and updated to include risk rating.Completion Date: 03-02-2023
• Incidents are audited on a monthly basis in line with the CHO1 annual schedule of audits. Completion Date: 19-01-2023
• Individual resident's risks are reviewed quarterly or sooner if required. Completion Date: 03-02-2023
• The HSE's Incident management system is implemented in this designated centre.
• Positive behavior support plans are reviewed monthly. Given the increase in behaviors

of concerns this has now been increased to fortnightly reviews 17-01-2023.
• All staff are trained in Do the Right Thing: HSE Risk and Incident Management. All staff will undertake refresher training in this. Completion Date: 28-02-2023
• Two Designated Officers support this Designated Centre and this information has been updated within the centre. All staff have been made aware of this update.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To ensure compliance with regulation 7 the following has actions have been undertaken:
• The Person in Charge has completed a further review of the staffing requirements to meet the assessed needs of the residents and the recommendation from the Multidisciplinary Team. Completion Date: 03-02-2023
• The Person in Charge has prepared and submitted an updated business case for additional staff to support the changing needs of residents within the Designated Centre. In the interim regular agency staff and dayservice staff will support this designated centre. Completion Date: 30-06-2023
• The requirment for Nursing support for this centre has been reviewed, is in place and is now reflected on the roster. Completion Date: 03-02-2023
• The Person in Charge is now rostered and present a minimum 2-3 day a week in Naomh Aine and will be available on phone as required to support staff. This will be kept under review to assess the support required on a weekly basis Completion Date: 03-02-2023
• The Donegal Disability Services Out of hours on call support is available to staff from 1700-0900hrs, weekends and public holidays.
• Each residents Positive Behaviour Support Plan is maintained in an 'Active Folder' which travels with the resident to Day Services. This is sign posted in each residents care plan to reflect where the folder is located. Completion Date: 03-02-2023.
• All staff have completed Studio 111 training. Completion Date: 03-02-2023.
• Monthly meetings to discuss Positive Behavior Support Plans are held with the Person in Charge, Named Nurses, Senior Psychologist, CNS and staff. This has now increased to fortnightly given the current presentation of one resident.
• The 3 stage Preliminary Screening Form has been received on the 20/01/2023 from the safeguarding and protection team and has been included in the residents care plan.
• The Person in Charge, Registered Provider and the Chief Officer are in the process of liaising with Letterkenny University Hospital to provide a clear pathway for diagnostic intervention for a previously diagnosed medical condition. Date: 03-02-2023.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The registered provider shall protect residents from all forms of abuse.

To ensure compliance with regulation 8 the following has actions have been taken:

• Positive behavior support plans are reviewed monthly. Given the increase in behaviors of concerns this has now been increased to fortnightly reviews 17-01-2023.
• All staff have undertaken training in safeguarding. Completion Date: 03-02-2023
• All staff are trained in Do the Right Thing: HSE Risk and Incident Management. All staff will undertake refresher training in this. Completion Date: 28-02-2023
• Two Designated Officers support this Designated Centre and this information has been updated within the centre. All staff have been made aware of this update.
• All staff have read and signed the most up to date Positive Behaviour Support Plan for one resident. Completion Date: 03-02-2023
• The HSE's Incident management system is implemented in this Designated Centre
• Monthly meetings to discuss Positive Behavior support plans are held with the Person in Charge, named nurses, Senior psychologist, CNS and staff or as required.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure compliance with regulation 09 the following has actions have been taken:

• A second transport is available as required to support residents choice of outings Completion Date: 03-02-2023
• Additional Day services has been made available for 3 residents. Completion Date: 03-02-2023
• Weekly residents meetings continue, easy read material on consent and human rights and complaints are on the agenda and will be discussed at the next residents meeting Completion Date: 03-02-2023
• The Donegal Disability Services recently reviewed Policy on the Management of Feedback (Complaints, Complements and Comments) is now available within this Designated Centre. Complaints easy read material has been made available to all residents. Completion Date:03-02-2023
• All staff have completed 4 modules of Applying Human rights-based Approach in Health and Social Care. Completion Date: 03-02-2023
• A referral has been completed for all residents to Social Work and Advocacy Completion Date: 03-02-2023

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2023
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	30/06/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery	Not Compliant	Orange	30/06/2023

	of care and support in accordance with the statement of purpose.			
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.	Not Compliant	Orange	30/06/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	30/06/2023
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to	Substantially Compliant	Yellow	28/02/2023

	in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	28/02/2023
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Not Compliant	Orange	28/02/2023

Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	28/02/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/06/2023
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	30/06/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2023
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to	Not Compliant	Orange	03/02/2023

	exercise choice and control in his or her daily life.			