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:	Dunshenny House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	25 October 2022
Centre ID:	OSV-0007987
Fieldwork ID:	MON-0036899

About the designated centre

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

Dunshenny House provides full-time residential care to adults with moderate to severe intellectual disability. The service comprises one building which is located in a rural area, close to a busy town. Residents are supported with co-existing conditions such as mental health illness and/or behaviours of concern, special communication needs, physical illness and conditions such as epilepsy and diabetes. Dunshenny House is accessible for people who are wheelchair users. Residents are supported by a qualified team of nurses and healthcare assistants who provide 24 hour care. Active night duty arrangements are in place.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 25 October 2022	09:30hrs to 16:30hrs	Úna McDermott	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. Inspector 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 in Dunshenny, 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. However, it was found on this inspection that improvements were required with the statement of purpose, the staffing arrangements, the systems used to provide staff training and the capacity of the person in charge and the provider to provide and sustain the governance, management and oversight of the designated centre. Furthermore, an urgent compliance plan was issued due to risks identified in relation to fire precautions (regulation 28). These will be discussed in later in this report.

There were three residents living in Dunshenny at the time of inspection. Two residents lived in the main house and one resident lived in an annex to the main building. The provider had submitted an application to vary a condition of registration and the work to the premises was completed since the last inspection. This meant that residents in the main house had access to a sitting area which was separate to the kitchen and this offerred a quiet area to relax or watch television.

During the course of this inspection, the inspector met with the person in charge and with two staff members. The acting assistant director of nursing joined the feedback meeting by telephone. On the day of inpsection, the person in charge was providing cover for a nurse that was on leave. This will be expanded on later in this report.

The residents at Dunshenny House did not attend a structured day service. The person in charge told the inspector that this was their preference and that decisions were made in consultation with the residents' families and their multi-disciplinary teams. As an alternative, the residents had access to a high level of staff support

which was in line with their assessed needs and a range of home and community based activities were provided on a day-to-day basis. Residents also had the opportunity to go on longer trips. For example; recently one resident went to a hotel for a music event and another went on a spa break.

On arrival to Dunshenny, the inspector met with two residents. One resident was watching a movie of their choice in the sitting room. Although they did not speak with the inspector, they were observed smiling when music played on the television. The staff on duty told the inspector that the resident had not slept well the previous night and therfore a relaxing morning was planned. They said that the resident enjoyed the quiet sitting room and that the changes to the premises as described above, were very positive. They added that they would observe the residents wellbeing during the morning and later, they would go for a walk, if the resident choose to do so. A second resident was observed spending time with a staff member in the kitchen. The staff member was preparing a nutritious and freshly cooked dessert for the residents to enjoy. The resident did not engage in this activity but choose to sit at the table and from time to time they would interact with the staff member by initiating a joke or requesting a cup of tea. In general, the atmosphere was calm, homely and welcoming. The staff on duty in the main house were respectful in their interactions with residents, were familiar with their communication needs and provided support promptly when requested. Furthemore, the inspector found that the premises was adapted based on the residents needs, the plans for the day adapted based on the residents choice and that overall residents rights were respected.

Later, the inspector met with the resident living in the annex to the building. This was a very pleasant living space and the resident was observed drinking tea while interacting with staff. It was evident that the staff on duty were very aware of the residents behaviour support needs and had the knowledge and skills required to respond appropriately. They told the inspector that the resident was going to meet with their family later that afternoon. As part of this trip, the resident enjoyed going to the shop to purchase personal items. The resident appeared content in their home. They spoke briefly to the inspector and then requested to be alone. This showed that the resident was comfortable with making decisions and requests and that these were supported and respected.

The inspector completed a short tour of the centre. It provided a very pleasant living enviroment which was clean, tidy and well maintained. The entrance area was well presented with themed decorations for Halloween and an area for outdoor sensory activities was provided. The entrance hall was bright and welcoming. There was a COVID-19 safety pause station in place where checks took place and hand sanitiser and face masks were provided. A notice board was used to display the names of the staff on duty and the plans for the day. The kitchen and combined dining room was clean, tidy and spacious. It was well equipped and there was a sufficient supply of nutritious food available. The sitting room provided a very pleasant space for residents to enjoy. The inspector observed one bedroom on the day of inspection and it was found to be warm, cosy and personally decorated. Similarly, the annex to the building was homely and comfortable. It was personally decorated and well designed for the resident's needs. The garden area was well presented and well

maintained. Level access was provided to the rear of the property since the last inspection and the plans to provide an outdoor sheltered area for residents to sit in and for storage was in progress. Later in the day, a routine weekly fire drill was completed. During this process, the person in charge found that a door on the second floor did not close correctly. As previously stated, an urgent compliance plan was issued which will be further addressed under regulation 28 below.

From observation in the centre, conversations with residents and staff, and information viewed during the inspection, it was evident that residents had a good quality of life, had choices in their daily lives, and were busy with activities that they enjoyed, both in the centre and in the local community. Throughout the inspection it was very clear that the person in charge and staff prioritised the well being, social preferences, independence and quality of life of residents. However, it was evident that the residents in this designated centre had a range of high support needs and that consistency of nursing and allied health care support was required. As previously stated, the person in charge was providing nurse cover on the day of inspection. They told the inspector that they were required to provide cover on a regular basis and that there were ongoing staff replacement difficulties in the centre. This meant that the person in charge was required to prioritise the care and support of the residents and therefore, were unable to carry out other administrative requirements. This impacted on the quality of governance and management provided in the centre.

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

Capacity and capability

This inspection was a follow up to the targeted inspection programme that took place in CHO1 in January 2022. A follow up to the compliance plan of the overview reported was submitted to the Chief Inspector of Social Service in July 2022. During the course of this inspection, it was noted that most actions had been completed, or were in the process of being completed. However, further improvements were required with the statement of purpose, the staffing arrangements, the systems used to provide staff training and the capacity of the person in charge and the provider to provide adequate governance, management and oversight of the designated centre.

The management structure in this designated centre consisted of a person in charge who reported to the acting director of nursing (ADON). The person in charge had responsibility for one other designated centre. They told the inspector that under typical circumstances that they had the capacity to do so. However, ongoing staff

cover and staff replacement concerns impacted on their ability to manage their work practices to the standard that they wished. The inspector reviewed the statement of purpose and found that due to a recent appointment the organisational structure and governance arrangements outlined required review and updating. A plan was in place for this to be actioned.

Staffing arrangements were reviewed as part of the inspection. The skill mix included nursing staff and healthcare assistants. There was a planned and actual staff roster in place which showed that there was an adequate number of staff working to meet with the residents assessed needs. However, on review of the roster, the inspector saw numerous changes where the person in charge and the staff team were required to work additional hours in order to ensure adequate staffing levels were provided. In some cases, staff reported that they were willing and had the capacity to do so. On other occasions, this impacted on the quality and safety of the service provided. For example, during a sample of the previous ten weeks, the person in charge had worked extra hours on eight of the weeks reviewed. Furthermore, on the day of inspection, three staff reported to the person in charge by telephone as they were unable to attend for duty over the following days. This meant that the person in charge was required to provide nursing cover during the day, while seeking replacement staff for six vacant shifts. The inspector observed the process used and by the end of the inspection, two shifts were covered through additional hours provided by the staff team or by agency staff that were familiar with the residents. One shift was covered by a new agency staff member. Three shifts remained vacant and work on staff replacement was ongoing. This meant that every effort was made by the person in charge and the staff team to ensure that familiar and consistent staff members were available in order to support the residents' assessed needs. Therefore, there was no impact on the lived experience of the residents. However, this was very challenging, not always possible and due to the added expectations on some staff members is was not sustainable.

The inspector reviewed the arrangement in place to support the staff during the absence of the person in charge. Since the last inspection, the provider had established a formal on-call arrangement for use in the evenings and at weekends in the event that staff required advice or support. However, on review of the protocol the inspector found that this arrangement covered emergencies only. These did not include matters pertaining to staff replacement, unless all options were exhausted by the senior staff on duty in the first instance. Therefore, an informal arrangement whereby staff would contact the person in charge remained in place. This was highlighted on the previous inspection and required review.

A review of training records in the centre showed that appropriate staff training was provided as part of a continuous professional development programme. A staff training matrix was recently introduced and details of staff training were logged. A sample of training records reviewed demonstrated that in general, staff members had competed the mandatory and refresher training as required. However, two staff required refresher training in safeguarding of vulnerable adults as it had expired recently. Eight staff required core training in positive behaviour support and three staff required refresher training. The person in charge told the inspector that it was difficult to align training dates with the shift patterns and with the staff replacement

needs of the centre.

A new programme of formal supervision was recently introduced to the service. The person in charge confirmed that their supervision with their line manager was completed and up to date. However, the person in charge said that due to other priorities in the centre, the schedule for supervision staff sessions with the staff team was in progress and not finalised. This required review.

During this inspection, actions relating to the providers commitment to strengthen the governance and management systems in place in its Donegal services were reviewed and all were found to be completed or progressing. The person in charge told the inspector that where practical, they attended the area meetings and the bi-monthly person in charge meetings arranged, however due to staffing concerns in the centre, this was not always possible. They confirmed that information discussed was circulated and a sample of meeting minutes were presented for review. At service level, staff governance meetings were arranged. The minutes of a meeting were reviewed and agenda items included safeguarding, quality and risk and infection prevention and control (IPC). However, only three of twenty staff were in attendance.

The provider-led unannounced six monthly audit was completed in February 2022. It identified a number of areas for improvement, including that the person in charge was working above the hours contracted. Furthermore, it noted the difficulties in releasing staff members to attending training. This audit was out-of-date and this required review. The annual review of care and support provided was completed in March 2022. The provider had introduced a new audit schedule recently and corresponding audits were reviewed by the inspector. Audits were completed on complaints and the environment (quarterly), incidents and restrictive practices (monthly) and in addition, there were a number of weekly and daily audits in place. However, the inspector found that two of the audits from the sample reviewed were out of date.

The centre had a quality improvement plan (QIP) which contain all actions arising from the provider audits, inspections by the Health Information and Quality Authority (HIQA) and a self-assessment audit by the person in charge. The person in charge showed the inspector the most up-to-date QIP and spoke about actions identified which included the requirement to provided additional staff to support the governance and oversight of the designated centre. This action was ongoing.

Overall, the inspector found that the person in charge and the staff team at Dunshenny had a high level of professional commitment which was evident on the day of inspection. However, concerns in relation to staffing impacted on the quality and safety of the service provided, and the governance and management systems put in place by the provider were not working.

The next section of this report will provide a description of the care and support that residents received and if it was of good quality and ensured that residents were safe.

Regulation 15: Staffing

The provider had an adequate skill mix and number of staff in place and nursing care was provided. However, due to ongoing staff shortages the roster was changed regularly and this impacted on the provider's ability to ensure continuity of care and support was provided in line with the residents' assessed behaviour support needs. Improvement was required in the following area:

- To ensure that the consistency of staff and continuity of care is provided.
- To ensure that the on-call arrangements in place are effective.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Access to appropriate training, including refresher training was provided as part of a continuous professional development programme. A staff training matrix was in place. However, improvements were required in the following areas

- To ensure that systems were in place to release staff from duty in order to attend training.
- To ensure that all training modules were up to date
- To ensure that all staff had access to a formal supervision programme

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme in January 2022, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO1. All actions were reviewed with the person in charge on the day of inspection. All of the ten meetings and committees were in place. In addition, the audit review had commenced and a new audit schedule was in place.

However, at a local level, the inspector found that significant improvement was required with the governance systems and processes in place in Dunshenny House

to ensure that the service provided was a safe service. Improvements were required in the following areas;

- To ensure that the statement of purpose met with the requirements of the regulation
- To ensure that the consistency of staff and continuity of care is provided.
- To ensure that all actions identified in previous inspection reports were completed and effective. For example, an action regarding on-call staffing arrangements was in place but was not working
- To ensure that systems were in place to release staff from duty in order to attend training.
- To ensure that all training modules were up to date
- To ensure that all staff had access to a formal supervision programme

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which was subject to regular review. However, it was not in line with the requirements of Schedule 1 of the regulations and improvement was required in the following area:

- To ensure that the management, staffing and organisational structure of the service is an accurate reflection of the service provided.

Judgment: Substantially compliant

Quality and safety

Residents living at Dunshenny House were provided with a good level of care and support and the environment provided was very pleasant and homely. As previous outlined, it was evident that the staff were committed to their work practices and the atmosphere was calm and welcoming.

As outlined, all residents were at home on the day of inspection. A range of home based and community based activities were provided. In addition, the person in charge told the inspector that residents were supported to have ongoing contact with their family members and one resident had planned to meet with family later that day.

The inspector reviewed a sample of residents' care plans and person-centred plans. The review found that annual reviews were taking place, that they were person-centred and where possible residents' families were involved in this process. Each

resident had a named keyworker and there was evidence of goals agreed and pursued. For example, one resident had a picture based book in their bedroom which showed activities that they had completed. These included meeting with family, picnics, sporting events, music events and eating out. The inspector could see that the resident enjoyed this visual diary and that it was regularly updated.

Residents had access to the services of a general practitioner and to allied health professionals if required. They attended physiotherapy, dietitics, and mental health services if required. Where additional support was required, this was acknowledged and pursued. For example one resident was on a waiting list for a cranial specialist as recommended by their GP and multi-disciplinary team. Furthermore, each resident had a nursing assessment completed and a health passport in place to assist and support if a hospital transfer was required.

Residents that required support with behaviours of concern had positive behaviour support plans in place. These were reviewed and updated regularly and there was evidence of the involvement of allied health professionals in this process. For example, additional support from a nurse with experience in positive behaviour support was provided. Restrictive practices were in use in this centre. There was a site specific protocol in place which was reviewed in June 2022. Furthermore, a restrictive practice log was in use and this was reviewed monthly. However, the inspector found that due to difficulties with staff replacement and as discussed previously, eight staff required core training in positive behaviour support and three staff required refresher training. In addition, the inspector found that one action from the provider's action plan required improvement. This was the fact that the induction pack used at the designated centre had not been reviewed or updated by the person in charge and their manager, in line with the requirements of the provider's action plan.

The provider had ensured that measures were in place to ensure that residents were safeguarding and protected from abuse. For example, the person in charge acted as designated officer and this was prominently displayed on the notice board. Residents requiring support with personal care had intimate care plans completed and the majority of staff had completed training in safeguarding and protection. Two staff had training completed which expired recently and plans for refresher training were in place, which were dependent on the ability of the person in charge to first and foremost provide sufficient staff for the centre. In relation to the provider's compliance plan submitted, three actions remained outstanding. These included; the requirement to provide a policy on safe wifi provision which was reported to be progressing at national level, the requirement to attend sexuality awareness training, and the requirement to attend speak easy plus training. These matters required review.

The inspector found that the service at Dunshenny was provided in a way that respected the rights of the residents living there. Through observations at the centre, discussions with staff and a review of the documentation it was evident that residents were encouraged to express choices and exercise control in their daily lives. This was support through the staffs' knowledge of the residents and their ability to understand their individual methods of communication. Where a concern

arose, the person in charge was prompt in their ability to recognise the possibility of a rights issue and had put measures in place to address this. This related to a referral to the social work team in relation to a residents civil and political rights. In addition to this, all staff had completed training in positive behaviour support.

The provider had risk management systems in place which included a policy and procedure for risk management and a site specific safety statement which outlined emergency plans for the centre. A risk register was maintained and where risks were required to be escalated to senior management, this had been done. Core risks for the centre were identified and residents had individual risk assessments completed if required. However, some improvements were required to ensure that all risk assessments were up to date. For example, the risks in relation to the COVID-19 pandemic required reviewed as the control measures referred to the closure of services and the cancellation of meetings. This was not in line with current public health advice.

As stated at the beginning of this report, an urgent compliance plan was issued due to risks identified in relation to fire precautions (regulation 28). During a routine fire drill, the person in charge noted that a fire door upstairs did not close correctly. This matter was corrected shortly after the inspection. All other fire management systems reviewed on the day of inspection appeared effective. A fire policy was in place and this was up to date. Fire fighting equipment was inspected on a monthly basis and emergency lighting arrangements were checked weekly. In case of fire, clear evacuation procedures were provided and residents had an individual action plan which were reviewed in August 2022.

Overall, inspector found that the residents living at Dunshenny had a good day to day lived experience and were supported with their assessed needs. However, difficulties with staffing provision and replacement were impacting on the quality and safety of the service provided.

Regulation 26: Risk management procedures

The provider had risk management systems in place which included a policy and procedure for risk management and a site specific safety statement which outlined emergency plans for the centre. However, some improvements were required in the following areas:

To ensure that all risk assessments were up to date and in line with Infection Prevention and Control (IPC) public health advice

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had effective fire management systems in place. However, an urgent compliance plan was issued due to risks identified in relation to a fire door that did not close correctly during a routine fire drill.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that residents had a comprehensive assessment of the health, personal and social care needs which was carried out on an annual basis and was subject to regular review.

Judgment: Compliant

Regulation 6: Health care

The healthcare needs of residents were supported. Where medical treatment was recommended this was facilitated and where the services of allied health professionals was required this was provided.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements relating to positive behavioural support at the centre. One action related to the approval of MDT supports, three actions related to staff training and ensuring staff have knowledge about behaviour support plans and three actions related to the induction of new staff. All actions were reviewed with the person in charge on the day of inspection. Six actions were completed and one action remained outstanding. Therefore, improvement was required in the following area:

- To ensure that the induction pack used was reviewed and updated in line with the provider's action plan

In relation to this inspection, the inspector found that residents that required support with behaviours of concern had positive behaviour support plans in place. These were reviewed and updated regularly and there was evidence of the involvement of allied health professionals in this process. However, improvement was required in the following area:

- To ensure all staff had training in positive behaviour support

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements relating to protection at the centre. All actions were reviewed with the person in charge. At service level, the inspector found that measures were in place to ensure that residents were safeguarding and protected from abuse. However, in relation to the providers actions plan, ten actions were completed and three required improvement:

- To ensure that a policy on safe wifi provision is provided
- To ensure that staff attend sexuality awareness training
- To ensure that staff attend speak easy plus training.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector found that the service at Dunshenny was provided in a way that respected the rights of the residents living there. Through observations at the centre, discussions with staff and a review of the documentation it was evident that residents were encouraged to express choices and exercise control in their daily lives.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dunshenny House OSV-0007987

Inspection ID: MON-0036899

Date of inspection: 25/10/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15: Staffing, the following actions has taken place • A Review of the on call arrangements has taken place to ensure effective governance, this was also discussed at the Donegal PIC meeting on 17/11/2022 to ensure that all PIC's had relevant and current information relating to on-call arrangements. All staff have again been informed of the purpose and specifics guiding the on-call arrangements and have been advised that this is defined in the safety statement. PIC's have been informed at the Donegal PIC meetings to bring any issues identified with the on-call arrangements, however staff feel more confident and competent in using this system and there have been no issues thus far. • The PIC will complete a review of staffing levels within the Centre on an ongoing basis to ensure cover of absences in order to ensure staffing levels remain within the levels identified within the Statement of purpose. • Staff Nurse Position has been offered out to the current panel, in the interim vacancy is being filled by familiar staff and PIC from within our own staffing compliment. • Senior Management are currently working with the Human Resource Department and have attended recent employment fares with further fares planned in an additional efforts to recruit staff to the service.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with Regulation 16: Training and Staff Development the following actions will be taken. • PIC has reviewed the training matrix. • A training plan has been provided for each member of staff who will have completed all	

mandatory HSEland training by 15/12/2022.
• Practical/face to face training in respect of CPR has been scheduled over 3 days from 13-15 Dec 22. Further session to be arranged in Jan 23 to close out this requirement.
• Manual Handling Training has been scheduled for staff on 12/12/22. Follow up sessions will be arranged in Jan '23 to close out this requirement.
• All Staff have been advised of registering for SASS training online with completion dates given in order to close out this requirement these will run from Jan'23 and complete March 2023.
• Pic has scheduled dates for Studio 3 training from Jan'23 until April 2023 for completion
• PIC has scheduled performance achievement meetings with all staff. (30/11/2022)
• Performance Achievement meetings for all staff will be completed in December 2022 and January 2023 in order to ensure that adequate supervision is in place to support staff.

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

• Statement of Purpose to be updated to reflect new organizational charts and ensure that information for ADON is reflected. (Completed 12/12/2022
• All Documentation for staffing has been submitted and escalated for approval as position became vacant.
• Staff Nurse position has been offered out to the current panel, in the interim vacancy is being filled by familiar staff and PIC from within our own staffing compliment.
• Form B's have been completed and submitted for the HCA position, awaiting recruitment
• A Review of the on call arrangements has taken place to ensure effective governance, this was also discussed at the Donegal PIC meeting on 17/11/2022 to ensure that all PIC's had relevant and current information relating to on-call arrangements. Staff have been advised not to contact the PIC when the PIC is not rostered for duty.
• PIC has reviewed the training matrix and has completed a training needs analysis, which has been provided to each staff member with dates for completion of outstanding training identified 30/11/2022. All staff to have all HSEland training up to date by 15/12/2022

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
To ensure compliance with Regulation 3: Statement of purpose, the following actions will be taken

• PIC to ensure Statement of Purpose is updated to reflect new organizational charts and ensure that information for ADON is reflected in same. 15/12/2022 (Completed 12/12/2022)
• PIC will ensure that Statement of Purpose is reviewed at least annually or sooner if required (Ongoing)

Regulation 26: Risk management	Substantially Compliant

procedures	
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: To ensure compliance with Regulation 26: Risk Management Procedures, the following actions has been completed • PIC to ensure that all risk assessments are up to date and in line with Infection Prevention and Control (IPC) public health advice 15/12/2022	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: To ensure compliance with Regulation 28: Fire Precautions the following actions have been completed: • The PIC contacted maintenance and all fire safety management systems are effective and in place. Completed 27/10/2022	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: To ensure compliance with Regulation 7: Behavioural Support, the following actions will be taken • BSP & attached sign sheet has been circulated for staff attention. His action has been completed by 30/11/2022 • Site Specific orientation, induction and induction checklist has been updated and put in place within the centre to be used going forward as required. 27/11/2022	
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 • All staff have been provided with an individual training needs analysis 31/11/2022 • The development of the WIFI policy is ongoing. The Digital Health lead held an information session with the PIC's and identified strategies that are in progress to ensure the use of online equipment safety for Service users. • A risk assessment been completed for safe use of internet • Staff to be advised of registering for SASS training online with completion dates given in order to close out this requirement. As per comment above on this training. • Speakeasy Plus for professionals training programmes has been completed by Health Promotion and Disability Services staff and Safeguarding & Protection Team. The training commenced in March 2022 and ran through to May 2022. This training provided a cohort of professionals working in the area of Intellectual Disability an opportunity to develop skills, knowledge and confidence in talking to people with Intellectual disabilities about relationships and sexuality.	

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	31/03/2023
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	31/01/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/11/2022
Regulation 23(1)(a)	The registered provider shall ensure that the	Not Compliant	Orange	12/12/2022

	designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	15/12/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	31/10/2022
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	12/12/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-	Substantially Compliant	Yellow	30/04/2023

	escalation and intervention techniques.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/03/2023