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

Issued by the Chief Inspector

Name of designated centre:	Cloghan
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	29 February 2024 and 01 March 2024
Centre ID:	OSV-0008154
Fieldwork ID:	MON-0042302

About the designated centre

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

The centre is located within a small campus setting which contains six other designated centres operated by the provider. Cloghan provides full-time residential care and support to three residents. The designated centre comprises a three bedded single-storey house. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. Residents are supported by a staff team of both nurses and care assistants.

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
Thursday 29 February 2024	14:25hrs to 18:30hrs	Angela McCormack	Lead
Friday 1 March 2024	10:00hrs to 14:00hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor compliance with the regulations and to follow up on actions from the previous inspection by the Health Information and Quality Authority (HIQA) completed in March 2023. The inspection was carried out over two half days. Overall, this inspection found that the health and wellbeing of residents who lived at Cloghan were promoted and that individualised care and support was provided. However, there were compatibility issues between residents, which led to one resident reporting that they felt unsafe at times. This will be elaborated on throughout the report.

On arrival to the centre, the inspector was greeted by a staff member who was working for the day. The person in charge arrived to the centre shortly after and was available throughout the inspection. Throughout the course of the inspection, the inspector got the opportunity to meet with all three residents and spoke with four staff members who were working over the inspection days.

The Chief Inspector of Social Services had been notified of 16 safeguarding concerns between residents in the past year. These mostly related to the negative impact of some residents' behaviours on their peers. The compatibility of residents living in this centre was an issue that was under review by the management team. One resident reported that they felt unsafe and that they wished to move out. This move to an alternative home was an action from the last inspection by HIQA. However, while ongoing discussions were taking place, there was still no definite plan for this move to occur as requested by the resident. On review of incidents that occurred and a sample of daily records, it was noted that at times residents were directly impacted due to the behaviours of others. For example; one resident's daily record from a day in February noted that this resident spent the afternoon in their bedroom resting, and to safeguard themselves from another resident displaying behaviours.

Notwithstanding the compatibility issues, the management team and staff were responsive to this and measures had been put in place to reduce the risks of safeguarding incidents from occurring. This included increased staffing to provide residents with 1:1 staffing and to facilitate separate activities. Staff spoken with said that the strategies were generally effective and that familiar staff working with residents was very important. The importance of consistent, familiar staff was also noted on residents' care and support plans. The local management team were aware of the compatibility issues in the centre and there was ongoing review with the multidisciplinary team (MDT), about an alternative residential placement for one resident.

With support from staff, all three residents met and spoke with the inspector individually. In addition, the lived experiences of residents were established through observation, a review of various documentation and speaking with staff and the management team. On the first afternoon of inspection, the inspector met with all residents briefly. One resident attended a day service each day as they chose, and

they met with the inspector on return. They showed the inspector their bedroom and were observed asking staff about who was due to work later and requesting to buy items for their bedroom. They showed the inspector a visual rota that they had in their bedroom that supported them to know what staff were working each day and night.

Another resident was met with in their preferred sitting-room where they were observed relaxing during the day. With support from staff, they spoke about family members, and showed the inspector their family photographs displayed on the wall.

One resident was met with in the kitchen where they were observed sitting with staff having finished their supper. They spoke briefly with the inspector with the support of staff. When leaving, the resident walked the inspector out to the door and said goodbye. Staff were observed to be responsive to residents' communication and were treating residents in a caring and respectful manner.

Residents were supported to either attend an external day service or do activities from their home in line with their individual wishes. Activities that residents were reported to enjoy included; visiting family members, going to family events, going to religious amenities of choice, gardening, going out for meals, attending music sessions in the local pub, going for day trips and one resident attended a weekly community group to meet with people of similar age.

On the second day, all residents were met with again. One resident was relaxing on a bench outside the front door and they greeted the inspector and spoke briefly about their plans for the day. One resident agreed to speak with the inspector, with support from staff. They showed the inspector a communication aid that they used and demonstrated how to use it. It was observed, and they acknowledged, that they found it difficult to use at times. Staff reported that this was under review.

One resident spoke about their wish to move out of Cloghan. When asked, they said that they did not feel safe, and gestured a 'hitting' motion. As stated above there were ongoing discussions occurring about this and efforts made to source a suitable, alternative home for this resident.

The inspector got the opportunity to speak with four staff throughout the inspection. A number of staff spoken with had worked in the service for a number of years. It was evident that they were very knowledgeable about the support needs of each resident. Staff talked about residents' individual needs and communications. Staff appeared very knowledgeable about residents' behaviour support plans and measures contained in safeguarding plans. Staff were observed supporting residents in line with the care plans and in a respectful manner.

When asked, staff said that they had completed 'human rights' training. A review of documentation found that human rights were promoted through discussion with residents at weekly meetings, where residents were supported to understand rights and safeguarding by using easy-to-read documentation. It was also noted that information was given to residents about the upcoming referendum and the choice to vote.

Cloghan house was found to be well maintained, nicely decorated, clean and homely. Since the last inspection by HIQA in March 2023, some internal work had been completed. This included; repainting of internal walls, new furniture was in place and new flooring had been installed in the hallway. There were plans in progress to get the external walls re-painted. A notice board in the hallway displayed easy-to-read posters and information on fire evacuation procedures, the procedure for making complaints, national advocacy information, a pictorial staff roster and infection prevention and control protocols.

Each resident had their own bedroom which had been personalised to their individual preferences with personal effects and photographs. Some residents also had their own television in their bedroom. One resident was reported to prefer minimal furnishings in their bedroom, and this was observed to be in place.

Residents had access to a garden area to the side of the property. The garden was decorated with potted shrubs, flowers and garden ornaments. There was garden furniture for residents to sit out if they chose to. In addition, there was a bench outside the front door, that some residents liked to relax on.

Overall, this inspection found that Cloghan provided person-centred care and support and strived to ensure that residents' wellbeing were protected. However, until compatibility issues were addressed the safeguarding risks remained in this centre.

The next sections of the report describe the governance and management arrangements and about how this impacts on the quality and safety of care and support provided in the designated centre.

Capacity and capability

Overall, this inspection found that there was a clear governance structure and arrangements for the ongoing monitoring of systems. However, due to unforeseen circumstances whereby members of the local management team had to take unplanned leave of varying durations in recent months, this impacted on the management of the centre and led to gaps in audits being completed for example. These gaps did not result in a high risk to residents, but could create a risk that issues could be missed. However, since the person in charge's return from leave, these gaps had been identified and a plan had been developed to address these.

The local management team comprised a person in charge who reported to the Assistant Director of Nursing (ADON). The person in charge was supported in their role by a clinical nurse manager 1 (CNM1), who completed some management tasks. Both the person in charge and CNM1 had responsibility for one other designated centre which was located nearby. As mentioned previously, due to unforeseen circumstances both the person in charge and CNM1 were on unplanned

leave for a number of weeks at the same time.

The staffing skill mix consisted of nurses and healthcare assistants. There were three staff working during day hours and two waking staff every night. Staff spoken with reported that the staffing arrangements were generally effective in supporting residents with behaviours and in managing safeguarding risks. However, it was noted verbally and in residents' support plans, that familiar staff was an important requirement in supporting residents with behaviours.

A review of the roster showed that there were some staffing gaps as a result of leave. These gaps for the most part were filled by regular agency staff. This helped to promote continuity of care to residents. However, on a few days over recent months, the gaps in staffing meant that there wasn't always a permanent staff member on duty. The local management team spoke about following up with the provider to address these gaps, including an upcoming planned gap in the CNM1 position. In addition, a review of the full time equivalent (FTE) in the Statement of Purpose required review to ensure that the FTE accurately reflected the staffing requirements to meet the assessed needs of residents.

A review of the training matrix found that staff were provided with training in fire safety, behaviour management, safeguarding and recommended training noted in behaviour support plans. In addition, this service had identified that training in communication supports was required. This was an action identified tin the provider's annual review and was in progress. Some staff had undertaken this training with a number of staff due to complete this. This is elaborated on under Regulation 10: Communication.

Staff were facilitated to raise concerns or topics for discussion through team meetings. These meetings covered a range of topics including safeguarding. However, there were gaps in the meetings being held due to management team being on leave. Since their return the person in charge had scheduled up a number of meetings, and included options for staff to attend through conference call if they wished, so as to maximise the attendance at these meetings.

The systems in place for monitoring and oversight of the centre included an annual schedule of audits to be completed at set intervals throughout the year. Areas that were under regular auditing included; finances, medication, restrictive practices, safeguarding, complaints, health and safety, fire safety, and incidents. However, as mentioned earlier, there were some gaps in the completion of audits over the two months that the management team were on leave.

Th provider completed unannounced visits and an annual review of the service as require under the regulations. Written reports were available, with actions identified to improve the service. The service had a quality improvement plan (QIP) which included actions identified through the provider audits, and HIQA inspections for example. This had been reviewed and updated with the person in charge and ADON the week of the inspection where a number of actions had been identified with a plan to address them.

Overall, the systems in place helped to promote a safe and person-centred service

was provided to residents. However, due to unplanned leave by members of the management team, there were some gaps in the management systems. These had been identified by the person in charge since their return and actions to address them were in progress.

Regulation 15: Staffing

There was a planned and actual rota in place which was well maintained and reflected who was working on the days of inspection. In general residents were supported by a consistent staff team, however, the following was found;

- where staff were on long term sick leave gaps in the roster were covered by agency staff. While for the most part, this was covered by regular agency, there were days in recent months where there was no permanent staff on duty. This required review to ensure that where possible, staff who were familiar with residents' needs, were rostered on duty.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear governance structure in place in the centre with roles and responsibilities. Due to unforeseen unplanned leave for members of the management team in recent months, there were some gaps found in the monitoring arrangements. This had been identified by the management team since the return of the person in charge, and actions were updated on the centre's QIP and were in progress.

The following was found:

- there were gaps in the completion of some audits in line with the provider's schedule since the absence of the person in charge and CNM1
- there was a gap in the team meetings held since the local management team's absences and they were not occurring bi-monthly as required. A schedule to address this had been devised by the person in charge since their return from leave.
- the risk assessment documentation for individual residents had not been reviewed and updated in line with the time-frames identified by the provider
- one resident's personal emergency evacuation plan (PEEP) had not been updated since January 2023, despite this being an action from the previous inspection by HIQA
- an action on protection agreed as part of the previous HIQA inspection compliance plan had not been achieved in the time frames agreed

- the statement of purpose required review to reflect the accurate FTE required to support the assessed needs of residents

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge ensured that all the required notifications were submitted to the Chief Inspector of Social Services.

Judgment: Compliant

Quality and safety

Overall, it was found that residents living in Cloghan were provided with person-centred care and support. There were systems in place to ensure that residents' needs were monitored and that any changes in need were responded to. However, there remained incompatibility between residents which created a protection risk at times. In addition, some residents required further supports with communication. The local management team were aware of these issues and these were under ongoing review.

The person in charge ensured that each resident had a comprehensive assessment completed of their health, personal and social care needs. A range of care and support plans were develop to guide staff in the supports required. Residents' needs were found to be kept under ongoing review. Staff spoken with were knowledgeable about the individual support needs of residents and this was observed in practice on the days of inspection.

This inspection found that human rights were promoted in the centre. Residents were supported to practice their faith and to vote, in line with their wishes. Residents were consulted about the running of the centre through regular residents' meetings. Easy-to-read versions of various topics were available to support discussions, including information on complaints, advocacy, safeguarding and 'human rights'.

Where residents required supports with behaviours, comprehensive behaviour support plans were in place. These clearly identified triggers to behaviours and contained guidance for staff on how to best support residents. These plans and reviews included MDT input.

Restrictive practices used were found to be assessed and kept under regular review to ensure that they were the least restrictive option and proportionate to any risks

identified. This included ongoing monitoring of the use of PRN (a medicine only taken as required) medicine, for which there were protocols in place.

As mentioned earlier, some residents living in Cloghan required supports with communication. Ongoing MDT reviews occurred to review residents' needs, including communication. Communication aids were being trialled with some residents. The inspector was informed about a plan for all staff to undertake training in communication methods, which aimed to enhance the supports provided to residents to meet their communication needs. At the time of inspection, this action was not fully completed.

There were good arrangements in place to ensure fire safety in the centre; including a system for ongoing auditing and checking of fire safety. Regular fire drills were occurring to include different scenarios and with the maximum number of residents and minimum staffing levels. These were kept under review and risk assessed where issues occurred. One PEEP required updating following an unsuccessful evacuation.

There were arrangements in place for the management of risks, including emergency plans. However, while in general risks were well managed, the documentation of some risks, required review and updating in line with the provider's time frames and policy.

As noted previously, there were incompatibilities between residents living in Cloghan. This was under ongoing review through regular MDT meetings. The management team spoke about the discussions that were occurring to address the compatibility issues and to ensure that any move was appropriate and safe for all residents affected. Obstacles for this move included a lack of appropriate accommodation and possible compatibility issues in other houses. While there was no definite plan in place, this was being worked on. However, until the incompatibility was addressed, safeguarding risks remained.

In summary, this inspection found that the service provided to residents strived to ensure that it met residents' needs and provided them with person-centred care and support. Some improvements and progress on actions, as noted throughout the report would further enhance the good quality care and support provided.

Regulation 10: Communication

Residents had communication support plans in place and access to technological devices to augment communications. In addition, residents had access to personal mobile phones, telephones, music players and televisions in line with their individual preferences. Staff were observed to be knowledgeable about residents' communication supports and this was observed in practice. Training in communication had been added to the training plan for all staff. While some staff had completed the identified training, the following was found;

- six staff required training in 'talking mats' and eight staff required 'objects of

reference' training to support residents with their communication preferences

Judgment: Substantially compliant

Regulation 12: Personal possessions

Residents' finances were managed through a provider centralised system in line with their policy and procedures. Financial competency assessments were completed to identify what supports residents required with the management of their finances. Arrangements were in place for residents to order money each week and to have a cash balance in the centre for day-to-day spending. One resident met with pointed out where they ordered their money (an external office) and they were observed asking to purchase an item for their bedroom. Receipts and records were kept in the centre to record residents' individual spending. However the following was found

- it was not clear that residents, and their representatives (where relevant), were kept informed about the balance of residents' total wealth
- in addition, one resident's personal property inventory was not updated with purchases made, in line with the provider's policy

Judgment: Substantially compliant

Regulation 17: Premises

The design and layout of the house ensured that residents enjoyed a comfortable and homely environment. Each resident had their own bedroom in which to store their personal possessions. In addition, residents had access to either an en-suite facility from their bedroom or an individual bathroom. Where residents required aids and appliances these were in place. For example; individual shower chairs.

The house was found to be well maintained, clean and spacious for the numbers and needs of residents. There were suitable cooking and laundry facilities in place. Residents had access to a well maintained garden area and outdoor garden furniture on which they enjoyed relaxing .

Judgment: Compliant

Regulation 26: Risk management procedures

While risks in the centre and risks affecting residents appeared to be identified and

managed, there were gaps in the documentation in place. The following was found;

- the highest risk in the centre, as discussed with the person in charge was not clearly documented and assessed
- residents' personal risk assessment documentation had not been reviewed in line with the three monthly time line noted on the document

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for fire safety. These included; fire containment doors, a fire alarm system, emergency lights and fire fighting equipment. There were regular checks completed on the fire safety arrangements to ensure that they were functioning and fit for purpose. Staff completed training on fire safety. Regular fire drills were completed under different scenarios. Fire safety was discussed with residents at regular house meetings. Residents had PEEPs in place, however one resident's PEEP had not been updated as required. This oversight gap is covered under regulation 23: governance and management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that each resident had comprehensive assessments completed on their health, personal and social care needs. A range of care and support plans had been developed which provided guidance to staff on the supports that each resident required in various areas of care.

Annual review meetings were held to review residents' care and support, and which ensured the maximum participation of residents and their representatives, as relevant. In addition, each resident was supported to identify personal goals for the future which were kept under review to ensure that they were completed. Residents' personal plans were available in an accessible, easy-to-read format.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff working in Cloghan completed training in behaviour management. Residents who required supports with behaviors and stress management had comprehensive

support plans in place, which included input from MDT. These were found to be up to date. Staff spoken with were knowledgeable about the behavioural supports that residents required.

Restrictive practices in place in the centre were kept under ongoing review to ensure that they were the least restrictive option for the shortest duration and that they had a clear rationale for their use. In addition, the use of PRN chemical restraint was under ongoing review, as part of the auditing systems, to assess if there were any trends. This demonstrated good monitoring by the management team to ensure that the least restrictive options were used.

Judgment: Compliant

Regulation 8: Protection

Staff had undertaken training in safeguarding. There were policies and procedures in place for safeguarding and for the provision of intimate care. Safeguarding concerns were found to be followed up in line with the procedures. Staff spoken with were knowledgeable about what safeguarding measures were required to protect residents. Residents were supported to understand about how to keep safe through eay-to-read documentation and regular discussions at house meetings.

However, the following was found:

- while ongoing discussions were occurring at MDT level about the compatibility of residents in Cloghan including the request by one resident to move out, this resident reported that they remained feeling unsafe in Cloghan and that they did not know when their request to move out to a new home would be facilitated
- the provider failed to meet the time frame agreed for one resident to move to a new home in line with their wishes

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' rights were promoted in the centre. Residents' meetings occurred regularly where residents had the opportunity to make choices in their day-to-day lives and to plan activities. Residents were supported to understand various topics through a range of easy-to-read information, which included information on voting, advocacy, the management of their finances and rights.

One resident had been referred for support from a social worker to advocate for

them during a period of transition in their life.
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 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cloghan OSV-0008154

Inspection ID: MON-0042302

Date of inspection: 29/02/2024 and 01/03/2024

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• The Person in Charge has reviewed the rosters and will ensure that there is a staff member rostered each day who is familiar with the residents' needs. Date completed: 03/04/24
• The Person in Charge will continue to ensure that the centres roster is reviewed daily to ensure it is reflective of the staff on duty daily. Date completed: 03/04/24
• The Person in Charge in conjunction with the Director of Nursing and the Assistant Director of Nursing will complete a full review of Centre's staffing requirements and update the Statement of purpose to reflect the staffing required to meet the assessed needs of the service users. Date for completion: 30/04/24
• The Person in Charge has ensured that there are regular agency staff assigned to the centre to ensure consistency for all residents. Date completed: 03/04/24</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The position of Clinical Nurse manager 1 has been accepted and the person commenced in post on 03/04/2024. Date completed 03/04/2024
• The Person in Charge in conjunction with the Clinical Nurse Manager 1 has commenced a review of all audits in the centre in line with the audit schedule. Date to be Completed 15/04/24.
• A Governance meeting was held in the centre on March 19th 2024. The minutes of the meeting are available in the centre for staff to read and sign off on. Date completed 19/03/2024
• The Person in Charge has reviewed the schedule for governance meetings within the centre and developed a schedule of bi monthly meetings for 2024 which will be strictly adhered too. Date Completed 03/04/24
• The Person in Charge in conjunction with the Named Nurses have reviewed the Risk assessments for residents. All risk assessments are up to date and the Person in Charge</td></tr>
</table>

will ensure that they are reviewed quarterly or sooner if required. Date Completed 03/04/24
• The Personal Emergency Evacuation Plan has been reviewed and updated for all residents' in the centre. Date completed 04/03/24.
• The Person in Charge and Clinical Nurse Manager 1 in conjunction with the staff team and the multi-Disciplinary team will continue to progress compatibility for all residents. Meetings regarding compatibility are held on a monthly basis.
• The Person in Charge and the multi-Disciplinary team in liaison with the Director of Nursing and Assistant Director of Nursing continue to work with one particular resident to source accommodation that meets their needs in line with their will and preference. Date for completion 30/11/2024
• The Person in Charge in conjunction with the Director of Nursing and the Assistant Director of Nursing will complete a full review of Centre's staffing requirements and update the Statement of purpose to reflect the staffing requirements to meet the assessed needs of the service users. Date for completion: 30/04/24

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• The Person in Charge in liaison with the Speech and Language Therapist have developed a schedule of training dates for staff working in the centre to complete training on objects of reference and talking mats. Date for completion 30/06/2024
• The Person in Charge will ensure that all staff attend the scheduled communication training to support the needs of the residents in the centre. Date for completion 30/06/2024

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• The Person in Charge in liaison with the administrator have provided each resident with a quarterly statement of their finances. Date Completed 04/03/24
• Each resident will be supported by staff in reading and understanding their financial statements.
• A quarterly statement will be provided to each resident at the end of each financial quarter. Date Completed 04/03/24
• The Named Nurse for each resident has updated each residents' personal property inventory in line with the Providers policy. Date Completed 04/03/24
• The Person in Charge and Clinical Nurse Manager 1 will complete Understanding the National Financial Regulations training through HSELAND. Date for Completion 30/04/24

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge has reviewed and updated all risks for the centre to ensure the information contained and the risk rating is accurate. Date Completed 04/04/24
• The Person in Charge will ensure that all risks within the centre are reviewed quarterly

or sooner if required in line with the provider’s time frames and policy. Date Completed 31/03/24
• The Person in Charge in conjunction with the Named Nurses have reviewed the Risk assessments for residents. All risk assessments are up to date and the Person in Charge will ensure that they are reviewed quarterly or sooner if required. Date Completed 04/04/24

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• This centre is included in the overall decongregation plan for Ard Greine Court campus and there is a schedule of monthly compatibility and decongregation meetings to progress this process. This is an ongoing process.
• The Person in Charge and the multi-Disciplinary team in liaison with the Director of Nursing and Assistant Director of Nursing continue to work with one particular resident to source accommodation that meets their needs in line with their will and preference. The Person in charge and the multi-Disciplinary team and the estates department in liaison with Director of Nursing and Assistant Director of Nursing continue to work with this resident to source accommodation to meet their needs. Date for completion 30/11/2024.
• The Person in Chargeand staff in the centre has discussed this with the resident and this is recorded in their personal plan.
• The Person in Charge and the multi-Disciplinary team and the Estates Department in liaison with the Director of Nursing and Assistant Director of Nursing continue to work with all residents to source accommodation that meets their needs in line with their will and preference. Date for completion 31/12/2025
• The Person in Charge in conjunction with the staff team & multi disciplinary team will continue to progress compatibility for all residents. Meetings regarding compatibility are held on a monthly basis and a representative from the centre attends all meetings. Date for completion 06/07/2023 and ongoing

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	30/06/2024
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	30/04/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Substantially Compliant	Yellow	30/04/2024

	circumstances where staff are employed on a less than full-time basis.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2024
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	30/11/2024
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	04/04/2024
Regulation 08(2)	The registered provider shall protect residents	Not Compliant	Orange	31/12/2025

	from all forms of abuse.			