Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ballymacool Respite House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	05 July 2022
Centre ID:	OSV-0002517
Fieldwork ID:	MON-0031248

About the designated centre

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

Ballymacool is a large detached two storey house located in Co. Donegal providing short-term respite breaks to both children and adults with disabilities. The centre comprises of 5 bedrooms (2 en-suite), a fully equipped kitchen, a dining room and a sitting room on the ground floor and a large games room on the first floor. There are also bathroom and showering facilities on both floors. There is a large garden to the back of the property with a well equipped playground area for the children and a well maintained garden area to the front. Private parking is also available in the centre. The centre is in close proximity to a nearby town however, transport is provided for residents to go on social outings and drives. The centre is staffed with a full-time person in charge, a team of staff nurses and healthcare assistants. The staffing numbers and arrangements are flexible, based on the number of residents availing of report at any given time and on their assessed needs.

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
Tuesday 5 July 2022	11:20hrs to 18:00hrs	Alanna Ní Mhíocháin	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. This included 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 Health Information and Quality Authority (HIQA) website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced 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.

This centre consisted of a large two storey building on its own grounds at the edge of a town. The centre was registered to accommodate up to five residents at any one time. As this was a respite service, the number of resident staying in the centre on a given day was subject to change. There were five bedrooms in the centre, two of which were en-suite. The other bedrooms had access to a shared bathroom. Bathrooms and en-suites were equipped with level access showers. There was also a large bath that could accommodate residents who required support in relation to their mobility. The shared space in the centre consisted of a large sitting room, a kitchen, dining room, laundry room and a games room upstairs. There was also a staff office and a number of store rooms. Outside, the large grounds were very well maintained. The provider was in the process of completing a large sensory garden to the rear of the centre. When complete, the garden would be fully accessible to all residents. It had raised beds, paved walkways, a water feature, outdoor lighting, seating areas and outdoor play equipment that included swings, a slide and an in-ground trampoline. The person in charge reported that the plants had been chosen with a particular focus on colour and scent to enhance the sensory experience. The person in charge reported that the garden was near completion with plans for the addition of outdoor chalkboards and wall mounted planters.

The centre was nicely decorated and there were photographs of some of the residents on display throughout the building. Bedrooms were equipped with profiling beds and there were pieces of equipment available to support residents with their assessed needs, for example, a mobile hoist, shower trolley and shower chairs. The kitchen was well-stocked with fresh food and choices for residents' meals and snacks. The furniture in the communal rooms was clean and in good condition. Overall, the house was in good structural repair. However, it was noted that some areas in the house were in need of refurbishment. For example, the flooring at one of the emergency exit doors was damaged and tape was used to keep the area flat.

There were also areas of the wooden flooring that were scratched and chipped paint was noted in a number of rooms. This will be discussed later in the report.

On the day of inspection, there were four residents in the centre. The inspector had the opportunity to speak with three of the residents. The fourth resident was out for the day. Some talked about being in the centre before and that they were happy to be back on their holidays. They said that they enjoyed coming to the centre and could choose to go on outings or enjoy more relaxing activities in the centre. They talked about some of the activities that they liked to do during their time in the centre. Residents said that they liked their bedrooms and that the beds were comfortable. They talked about having their own televisions with internet access. They talked about watching their favourite television shows, films and streaming music that they enjoyed. Residents said that they were very happy with the food in the centre. They talked about the meal that they had enjoyed the evening before and each had chosen a different option. One resident spoke about how the food in the centre was made to a particular consistency that suited their needs and preferences. The residents said that the staff in the centre were nice and that they would be comfortable talking to them if they had any concerns or complaints. Later in the day, the inspector noted that the residents appeared very comfortable in each other's company and they were observed chatting and laughing together.

Staff were observed interacting with residents in a respectful and friendly manner. Staff offered choices to residents and these choices were respected. When residents asked for help, staff were quick to respond. Staff were knowledgeable on the needs of residents. There was a pleasant and relaxed atmosphere in the house. Residents were consulted on what they would like to do for the day and staff were available to support the residents with their chosen activity. The residents left the centre in the afternoon and this was facilitated by staff.

Overall, the inspector found that the service in this centre was of a good quality and that residents' choices were respected. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

As outlined above, the provider had submitted a compliance plan in response to the findings from the targeted inspections in January 2022. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in the centre. This included the introduction of regular meetings within the centre and across the service in the county. The person in charge gave information on the commencement of these scheduled meetings.

Within the centre, staff governance meetings occurred every two months in line with the provider's compliance plan. Minutes from these meetings were signed by all

staff. The person in charge also met with the area coordinator every second month, or more frequently, if required. At a network level, the safeguarding review meetings had commenced and the person in charge reported that these meetings facilitated shared learning across centres. There was a representative from the safeguarding team in attendance and the Garda liaison officer was also invited to attend. The governance for quality safety service improvement meetings had also commenced. On a county level, the persons in charge across the county met on a fortnightly basis. The person in charge reported that information from more senior management meetings was shared at this meeting. For example, the Human Rights Committee was an agenda item and progress from this group was shared with all persons in charge at the last meeting. The person in charge also reported that updates from the planned recruitment outlined in the provider's compliance plan was discussed at the fortnightly persons in charge meeting and that these were in process. The person in charge said that the new meetings meant that issues were not looked at in isolation but within the broader context of the service and that they enabled shared learning between centres.

The provider's compliance plan outlined that a review of audits completed in centres across the county was due for completion in April 2022. The person in charge reported that audits had been reviewed and that the provider was finalising a schedule of standardised audits to be rolled out in all centres but this had yet to be finalised.

Within the centre, there was an existing audit schedule that outlined audits that should be completed monthly, quarterly or annually. A review of these audits found that they were completed in line with this schedule. A number of staff had been identified to take a lead role in some aspects of service improvement. The person in charge said that one staff member had taken on the role of lead worker representative in relation to infection prevention and control, another had taken on the role of fire warden and a third staff member was health and safety representative. This group of staff met regularly with the person in charge to discuss audit findings and to ensure that actions identified were addressed. The centre also had a quality improvement plan that included findings from audits. The quality improvement plan also included actions from the provider's six-monthly unannounced audits and annual review into the quality and safety of care and support in the centre. The most recent six-monthly unannounced audit had occurred on 30/05/2022 and it identified specific actions that should be taken to improve service quality in the centre. These actions had named persons responsible for their completion and target timeframes. The most recent annual review was completed in December 2021. A review of this report found that not all issues identified in the report had been listed as requiring an action. For example, the report identified that the floor covering at the emergency exit needed to be replaced but this was not listed as an action item in the report and, as outlined above, this had not yet been addressed on the day of inspection over six months later.

Staffing arrangements in the centre were reviewed. The person in charge maintained a planned and actual staff roster that outlined the staff on duty. Given the nature of the service, staffing arrangements were flexible to ensure that there was an adequate number of staff on duty to meet the residents' assessed needs.

The person in charge reported that there were no vacancies in the centre and that there was a regular team of staff in place. There was access to nursing support in the centre at all times.

Staff training records in the centre were also reviewed. There was a number of mandatory training modules that had been identified by the provider for all staff. In addition, there was a number of training modules that were specific to the centre. Records indicated that all staff were fully up to date in their training in all of these modules. This included training by all staff in Sexuality Awareness in Supported Settings (SASS) which had been identified on the provider's compliance plan.

Overall, the inspector found that the staffing arrangements and skill-mix in this centre were appropriate to meet the needs of residents. Staff training was fully up to date in all areas. There was good oversight and management in this centre. However, some improvement was needed to ensure that all service issues that were identified during provider-led reviews were given specific targets for completion.

Regulation 15: Staffing

The person in charge maintained a planned and actual staff roster in the centre. The number and skill-mix of staff in the centre were adequate to meet the assessed needs of residents. There was a consistent team of staff in the centre to ensure continuity of service to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified a number of mandatory and site-specific training modules for staff in this centre. Records indicated that all staff were fully up to date in their training in these modules.

Judgment: Compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO1. At the time of inspection, the ten actions relating to governance

meetings had commenced. The action relating to audit review was in process but had not yet been completed.

In relation to the governance meetings, the person in charge said that the meetings between all persons in charge and the network Safeguarding Review Meeting were beneficial for shared learning between centres. The process of dissemination of information from senior management meetings to persons in charge had not yet been fully established. Minutes from senior management meetings were not available in the centre. However, the person in charge reported that relevant information from senior management meetings was shared at the fortnightly meetings between persons in charge.

The planned audit review that was due for completion in April 2022 had commenced but the project was not yet complete. The person in charge reported that the audit tools had been reviewed and updated. However, the schedule for these audits had yet to be completed and, therefore, the roll-out of the new audits had not yet occurred.

In this centre, audits were routinely completed to identify areas for service improvement. Actions from these audits were included in the centre's quality improvement plan and were discussed during meetings in the centre between the person in charge and other identified staff members who had been delegated duties in relation to fire safety, infection prevention and control, and health and safety. There were clear management structures and lines of accountability in this centre. The provider had completed six-monthly unannounced audits and an annual review into the quality and safety of care and support in the centre in line with the regulations. However, not all identified issues in the annual review were listed as action items in that report and had not yet been addressed on the day of inspection.

Judgment: Substantially compliant

Quality and safety

There was good practice in this centre in relation to the quality and safety of care provided to residents. Residents' personal plans reflected the residents' goals and wishes and gave guidance to staff on how to support residents. Residents' rights were promoted. However, improvement was required in relation to documentation relating to resident's risk assessments.

The provider had commenced a number of the actions relating to safeguarding that were identified in the compliance plan submitted following the targeted inspections in January 2022. The person in charge had received incident management and safeguarding training and had also received training on preliminary screening. A safeguarding log was in place in the centre and this was reviewed at the safeguarding network meeting. Staff training was included as an agenda item on meetings in the centre and at the meetings between persons in charge. As outlined

above, all staff in the centre were trained in SASS. The person in charge in this centre was also a designated officer and they outlined the support that they received from other designated officers in the network. This involved providing cover to other designated officers during periods of leave.

There was good practice in this centre in relation to safeguarding. A review of incidents found that they were recorded, reported and escalated appropriately. Incidents were reviewed monthly and any trends were identified. Actions to avoid the reoccurrence of incidents were identified. Where required, incidents were reported to the national safeguarding team. Safeguarding plans were developed and there was evidence that these plans were progressed. Residents had intimate care plans that gave clear guidance to staff on how to support residents. Staff were knowledgeable on the steps that should be taken if they had any safeguarding concerns. The contact details of the designated officer, complaints officer and confidential recipient were on display in the centre. These actions promoted the safety of residents in the centre. Where incidents did occur, these were addressed promptly and comprehensive measures put in place to ensure the safety of residents.

The inspector reviewed a sample of residents' personal plans. It was noted that an assessment of the residents' health, personal and social needs had been completed. Care plans to guide staff on how to support residents with their needs were devised from this assessment. Staff reported that they contacted residents' families or day-service providers in order to update plans prior to the residents' arrival at the centre. The care plans were also reviewed and updated following each period of respite. Given the nature of the service, residents set their personal goals upon arrival at the centre for their period of respite. The supports that were required to achieve those goals were identified.

In some cases, residents' personal plans also contained behaviour support plans. The plans outlined the behaviours that indicated that the resident was calm or becoming agitated. The plans gave guidance to staff on how to support the resident manage their behaviour. There was evidence of input from relevant healthcare professionals, for example, a clinical nurse specialist in behaviour. Some residents also had communication dictionaries that explained what certain behaviours indicated and what staff should do in response to those behaviours. Restrictive practices in the centre were audited to ensure that they were the least restrictive option. Medication to support residents manage their behaviour was also audited to ensure that there was clear guidance to staff on when medication should be administered. Staff talked about assisting relevant healthcare professionals with the development of residents' behaviour support plans. They were knowledgeable on the supports that were required by residents to manage their behaviour and could implement these strategies as required.

Positive behaviour support was also part of the provider's compliance plan. Discussion with the person in charge indicated that some aspects of the plan had been commenced. The person in charge reported that the appointment of additional multidisciplinary team members was in process and that updates on these appointment were included in the fortnightly persons in charge meeting. In relation

to staff induction, the person in charge reported that no new staff members had started in the centre in the previous six months but that staff induction was discussed at the meeting between persons in charge.

Risk assessments in the centre were reviewed. The person in charge maintained a risk register that outlined risks to the service as a whole. The risk assessments were specific to the centre and to the service. They identified the risks and the control measures that should be implemented to reduce the risk. The assessments were regularly reviewed. A number of individual risk assessments for residents were also reviewed. These also identified relevant risks and control measures. However, not all identified risks had a corresponding risk assessment. For example, one resident's assessment of need identified that a risk assessment should be in place in relation to tissue viability and the risk of absconsion. However, these assessments had not been completed. Not all risk assessments that were reviewed were updated in line with the provider's guidelines. In addition, some risk assessments included multiple issues and it was therefore unclear what control measures should be implemented in response to specific risks to the resident.

Residents' rights were respected in this centre. A residents' meeting was held with all residents when they started their periods of respite. These meetings ensured that residents had the opportunity to make choices in relation to their food and activities while in the centre. Residents were also informed of the complaints procedure in the centre and how to make a complaint. Throughout the inspection, it was noted that residents were offered choices by staff and that these choices were respected. Staff were respectful of the privacy and dignity of residents and were noted knocking on doors before entering the residents' rooms.

Overall, the service delivered in this centre was person centred and of a good quality. Residents were supported to engage in activities of their choosing and their rights were promoted.

Regulation 26: Risk management procedures

There were systems in place in the centre to identify, assess and control risks to residents and the service. There was a risk register in the centre that outlined risks to the service. Risk assessments had also been devised for individual residents. However, not all identified risks to residents had corresponding risk assessments and individual risk assessments did not always give clear guidance to staff on how to reduce risks.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social needs were assessed. Corresponding care plans were devised to guide staff on how best to support residents with these needs. Residents were supported to set personal goals during their respite in the centre. The supports needed to meet those goals were identified.

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.

The inspector reviewed three of these actions on the day of inspection; the approval of multidisciplinary supports and two actions relating to staff training. One of these actions had been completed. The other two actions had commenced but were not yet complete.

- Staff training was included as an agenda item in meetings in the centre.
- The inspector found that the multidisciplinary posts were in progress and that persons in charge were informed of the progress regarding these posts.
- The person in charge reported that staff identified training requirements during meetings and supervision and that this was escalated to senior management for approval. However, a formal training needs analysis in the centre had not taken place.

In the centre, all staff had received training in relation to supporting residents manage behaviours that are challenging and this training was up to date. Residents had behaviour support plans with input from relevant healthcare professionals. Restrictive practices, including the use of medication to support residents manage their behaviour, was audited and reviewed regularly to ensure that they were the least restrictive option for residents.

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.

The inspector reviewed nine of the actions on this inspection. Seven of the actions were complete.

- The person in charge had completed incident management and safeguarding training
- The person in charge had received training regarding preliminary screening and safeguarding plans
- A network safeguarding tracking log had been implemented
- Incidents in the centre were cross-referenced against safeguarding plans.
- Training schedules were included as agenda items in the minutes of governance meetings
- All staff in the centre had received training in SASS
- The network safeguarding review meetings had commenced.

Two of the actions had commenced but were not yet complete.

- As mentioned previously, the review of the audit schedule and tool pertaining to safeguarding had been commenced. The person in charge reported that the audits had been reviewed but that the schedule of audits had not yet been finalised. As a result, the new audits had not been rolled out across centres.
- The person in charge reported training that was requested by staff to senior management. However, as outlined previously, a formal training needs analysis had not been completed.

There were good safeguarding practices in the centre. Safeguarding plans were in place where needed and staff were knowledgeable of the steps that should be taken if they had any safeguarding concerns. Staff had received training in safeguarding. Incidents were recorded and escalated. Incidents and safeguarding plans were reviewed and analysed to identify trends.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The rights of residents were respected in the centre. Residents were supported to make choices regarding their preferred foods and activities in the centre. Their choices were respected. Resident meetings were held with residents when they arrived at the centre. Staff respected residents' privacy.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ballymacool Respite House OSV-0002517

Inspection ID: MON-0031248

Date of inspection: 05/07/2022

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 23: Governance and management	Substantially 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;

• A full review of audit was completed by the Regional Director of Nursing in conjunction with CNM3's across disability services in CHO1 (Completion Date: April 30th 2022).
• A number of actions have been identified from this review and these are currently being progressed.
• A revised and agreed annual schedule of audit for CHO1 Disability Services has been circulated across the CHO for implementation in August 2022 to include areas specific areas of audit identified by specific centres. A number of audits have been reviewed to date to include the following;
• Quarterly Fire Audit
• Monthly Incident Management Audit
• Monthly Financial Audit
The full review of all audits will be completed by 30th September 2022.

• Dissemination of information from senior management meetings to persons in charge is facilitated at the following forums;
• Donegal Person In Charge (PIC) fortnightly meetings.
• Individual Person in Charge (PIC) bi-monthly meetings with Director of Nursing.

• The PIC will revisit the Annual Review of 2021 to ensure that any issues identified in the report are added to a revised action items list and placed on the centre's QIP for immediate address.
• Provider Representatives have received training relating to PN Six-Monthly and Annual Reviews (Completion date: 12th May 2022).
• Going forward the Provider will ensure all identified issues in Annual Reviews are

detailed in the appropriate 'Improvement Plan' on the Annual Review Template.

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 Risk Management Procedures the following actions will be taken;
• The PIC in conjunction with Nursing Staff have reviewed the Core Nursing Assessment and Risk Assessments for one resident to ensure all necessary risk assessments are in place to meet the needs of this resident (Completion Date: 10/08/2022).
• The PIC will ensure that all Nursing Staff who have identified risk assessments as a requirement for individual residents have corresponding risk assessments in place. Risk Assessments will also be reviewed to ensure clear guidance on how to reduce risk is effectively recorded (Completion Date: 28th October 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 Positive Behaviour Support the following actions will be taken;
• The PIC has completed a Training Needs Analysis for the centre on 12/08/2022 and will coordinate the identified training requirements.

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;
• A full review of audit was completed by the Regional Director of Nursing in conjunction with CNM3's across disability services in CHO1 (Completion Date: April 30th 2022).
• A number of actions have been identified from this review and these are currently

being progressed.
• A revised and agreed annual schedule of audit for CHO1 Disability Services has been circulated across the CHO for implementation in August 2022 to include areas specific areas of audit identified by specific centres. A number of audits have been reviewed to date to include the following;
• Quarterly Fire Audit
• Monthly Incident Management Audit
• Monthly Financial Audit
The full review of all audits will be completed by 30th September 2022.

• The PIC has completed a Training Needs Analysis for the centre on 12/08/2022 and will coordinate the identified training requirements.

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 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	30/09/2022
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	28/10/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Substantially Compliant	Yellow	12/08/2022

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/09/2022