Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Dreenan Ard Greine Court
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	28 February 2022
Centre ID:	OSV-0005490
Fieldwork ID:	MON-0034496

About the designated centre

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

Dreenan provides full-time residential care and support for up to six adults with an intellectual disability. Dreenan comprises of a six bedroom bungalow and residents have access to communal facilities at the centre which include two sitting rooms, a dining room, a kitchenette, a laundry room and bathroom facilities and each resident has their own bedroom. The centre is located within a campus setting which contains six other designated centres operated by the provider. It is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and cafes. Residents are supported by a staff team of both nurses and health care assistants. During the day, residents are supported with their assessed needs by five staff members with one nurse being on duty at all times. At night-time, residents are supported by two staff, a nurse and health care assistant.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 28 February 2022	14:00hrs to 19:00hrs	Angela McCormack	Lead
Tuesday 1 March 2022	09:30hrs to 14:45hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

There were five residents living in Dreenan at the time of inspection. The inspector met with all five residents and staff supporting them over the course of the inspection. In general, residents were found to be supported in line with their assessed needs and they appeared comfortable in their home. However, one resident informed the inspector that they would like a new home and said that they would like to live with others with whom they had more in common.

Four residents did not communicate verbally; however they interacted briefly with the inspector on their own terms and with support from staff members. One resident who communicated verbally spent time speaking with the inspector alone on the first evening of the inspection, and also requested to speak with the inspector the following day, which they did so in the company of the person in charge.

One resident expressed that they would like to move out of Dreenan and said that they would like to live with other residents with whom they could talk. They said to the inspector that they liked to talk to others, and added that they could not talk with any of their peers in Dreenan due to their communication needs. They reported that they spend a lot of time in their bedroom listening to music, and they informed the inspector they their day services had stopped due to the impact of COVID19. They also mentioned about how they had a friend in a nearby centre with whom they used to meet and chat with, and said that this doesn't happen anymore. The compatibility issue in Dreenan will be discussed in more detail in the next sections of the report.

On arrival to the centre on the first afternoon of the inspection, the inspector met with a staff nurse who was supporting residents in Dreenan that day. One resident was reported to be in bed resting after an earlier medical appointment, and two residents were observed in the communal areas of the house in the company of staff members. Two staff members were reported to be on lunch break at the time. It was reported that there would usually be five staff on duty each day and two staff at night, with an additional staff working 'twlilight hours'. Staff who the inspector met with throughout the inspection said that there were sufficient numbers of staff on duty each day to meet residents' needs. Staff spoken with were knowledgeable about residents' care and support plans and were observed to be supporting residents in line with their needs. Staff members were observed to be treating residents in a dignified and respectful manner.

Documentation reviewed and discussions with residents and staff indicated that residents enjoyed going for bus drives, going out for tea, visiting family, receiving family visitors, listening to music, getting massages and doing gardening tasks. One resident described how they were not attending their day service at present, and staff explained that this was due to COVID outbreaks and staffing issues.

Some residents living in Dreenan had high support healthcare needs. A sample of residents' care and support plans reviewed found that appropriate supports were provided to residents in order to facilitate the best possible health and wellbeing outcomes. During the course of the inspection, residents were observed to be relaxed in their home, watching television, listening to music, making phone calls to family members and some residents were supported to go on bus outings. One resident was supported to spend time in a sensory room which was based in another building on the campus. One resident received a visitor during the afternoon of the first day, and this family member spoke with the inspector. They were complimentary of the care provided to their family member.

A review of documentation was completed which included reviews of management audits, residents' questionnaires, care plans and daily care notes. In general, it was found that residents were happy and content in their home and were supported in line with their assessed needs. However, as noted previously one resident expressed dissatisfaction to the inspector about their home and with whom they lived. It was noted that the resident was supported to lodge this as a complaint in February 2022. This had subsequently been closed out as it was reported that the resident had changed their mind. In addition, it was noted that a compatibility assessment completed in June 2021 had assessed the compatibilities between residents living in Dreenan and had identified that this resident would benefit from living with a more compatible peer group. The inspector found that progress on this was slow, and the resident appeared to be unaware of what, if any, plans there were in place to support with this.

Dreenan home was nicely decorated, warm and comfortable. Some improvements were required in the internal maintenance regarding a damaged door frame, and in promoting accessibiity for all residents to the kitchen. Each resident had their own bedroom that was personalised with photographs, soft furnishings and personal effects. One resident showed the inspector their bedroom and spoke about how they had chosen the colors for the walls. They also spoke about how they had a mini fridge in their bedroom to store their preferred food and drink items. The back garden area was spacious and was decorated with a number of colourful garden ornaments, which one resident reported that they liked to collect. The garden also had a basket ball hoop, garden furniture and plant containers. One resident was observed to be spending time in the garden walking around, during the inspection.

In general, there was evidence that care and support provided to residents was good; however one resident's expressed wish about their future living arrangements required a clear and time bound plan to be developed with them to support them with their life choices and the progression of this.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

Dreenan designated centre was one of seven designated centres based on a campus in Co. Donegal. This inspection was carried out to follow up on actions arising from the last inspection by the Health Information and Quality Authority (HIQA) in October 2021. Since April 2021, as part of the monitoring of all of the designated centres based on the Ard Greine campus, the provider was required to submit monthly updates on a quality improvement plan to HIQA. Actions included on this plan were also reviewed as part of this inspection particularly with regard to the management and oversight arrangements.

Since the last inspection the local governance and management arrangements included the addition of a clinical nurse manager 1 (CNM1) who commenced in November 2021. The person in charge had responsibility for an additional designated centre located on the campus, and was supported in their role by the CNM1 who also worked across these two designated centres. The implementation of this layer of management was part of the provider's improvement plan to support with the governance and operational management of the centre. During the inspection the inspector identified that some improvements were required in staffing arrangements, the maintenance of training records, premises, some aspects of residents' personal plans and in the reviews of some behavioural incidents. In addition, the oversight and monitoring arrangements required further strengthening to ensure that the auditing systems were effective in identifying, and subsequently ensuring, that actions for improvements were completed in a timely manner. These will be discussed in more detail throughout the report.

On arrival to the centre the inspector met with a staff nurse who facilitated the inspection until a member of the management team arrived to the centre. Both the person in charge and the CNM1 were on leave on the first day of the inspection, and the CNM1 came in on their day off to support with the facilitation of the inspection. The person in charge was available to facilitate the second part of the inspection the following day.

There was a planned and actual rota in place. A sample of roster records for the past three months were reviewed by the inspector. The management team reported that there was one health care assistant vacancy at this time. They explained that a review of rosters for the campus as a whole was in progress at present due to the recent reconfiguration of centres. The inspector was also informed that two staff were currently on leave in Dreenan due to injuries, which created some staffing gaps. In general, it was found that there was the appropriate number of staff in place to support with the assessed needs of residents, and there was a cohort of regular agency staff that was used to fill staff vacancies.

However, in a sample of rosters reviewed it was found that in addition to the regular agency staff, there were some weeks since November 2021 that additional staff were required. For example, in one instance 18 staff (in addition to the permanent and regular agency staff) were working some shifts on the roster over a two week period. This impacted on the continuity of care provided to residents. In addition, on the second day of inspection, one staff nurse who had not worked in the centre

previously was required to fill a staffing gap that day. While a comprehensive induction folder was in place for new staff and the person in charge was supporting this new staff on the day with their induction, the arrangements for staffing required improvements to ensure ongoing continuity of care to residents.

The staff training matrix and associated training records were reviewed. The inspector found that there were gaps in the training records maintained, which meant that the inspector could not verify that all staff had completed the required training. While the management team verbally assured the inspector that the temporary staff working in the centre had completed the mandatory training, improvements were required in the maintenance of records to verify this. The inspector was informed that training was provided for the regular agency staff in Studio III (the required behaviour management training), and said that this was completed in February 2022; however there was no records available to verify this. The management team advised that work was in progress to streamline the process with regard to maintaining training records for all agency staff. In addition, there was an outstanding training need identified for cardiopulmonary resuscitation (CPR) for a number of staff. This was noted to be an action on the centre's quality improvement plan (QIP), with a timeframe for completion identified for the end of March. Samples of other training programmes reviewed demonstrated that regular staff had completed training in hand hygiene, manual handling and safeguarding.

Staff received support and supervision through an annual personal development plan (PDP), which the person in charge reported was reviewed with the relevant staff mid year. The person in charge said that PDP meetings with all staff, with the exception of one that remained outstanding, were completed and a sample of records reviewed indicated this. Staff spoken with said that they felt supported, and that they felt that there was enough staff on duty to meet residents' needs.

Some improvements were noted in the oversight arrangements in place since the last HIQA inspection. Regular management meetings were held with the director of nursing (DON) and the managers under their remit, where a range of topics, including training, policies and staffing were discussed. In addition, a number of Quality and Patient Safety meetings had been held. A sample of minutes reviewed demonstrated an improvement in the oversight and monitoring arrangements with regard to incidents and issue that occurred in the centre. A review of incidents that occurred in the centre demonstrated that the person in charge ensured that notifications as required were submitted to the Chief Inspector of Social Services in line with the regulations.

However, further improvements were required to ensure that management audits were effective and robust in monitoring the centre on an ongoing basis. The provider had completed an unannounced audit in December 2021, with the previous audit completed in May 2021. However, a written record of the audit which occurred on 20 December 2021 was only received by the person in charge on 01/03/2022. It was noted that out of 17 actions identified, 15 actions identified a time-frame for these to be completed by the end of February 2022, which meant that the time-frame had passed by the time the person in charge received the report. The director of nursing informed the inspector that a new system was being developed to ensure

that audit reports would be sent to the person in charge in a timely manner.

In addition, actions required to achieve regulatory compliance which were identified through the HIQA inspection in October 2021, had not been reviewed and monitored as to the status of the action during the most recent provider audit. For example; the provider audit did not identify that an action relating to the premises would not be met within the time-frame agreed with HIQA in the compliance plan submitted. This demonstrated that the management oversight and monitoring required further improvements to ensure that the auditing systems were effective in identifying centre specific quality improvement actions and in ensuring regulatory compliance.

In addition, the inspector found that management audits and the centre's quality improvement plan did not include actions identified on inspection. For example; while the issue of incompatibility between residents which had been identified through a compatibility assessment in June 2021 was reported to be at the early stages of being progressed by the local management team, this was not included as an action on any of the audits. Furthermore, staff training that had been recommended following an occupational therapy (OT) sensory assessment for a resident in November 2021 had not been identified as a training need, and therefore not included as an action in the action plans. The deficits in the oversight and monitoring of the centre created risks that actions to improve the quality and safety of the care of residents would not be followed up in a timely manner.

In summary, while care and support provided to residents was generally good, some improvements were required in staffing arrangements, training and in management audits to ensure that there was effective monitoring of the centre on an ongoing basis. Improvements in these areas would ensure that quality improvement actions were appropriately identified and that regulatory compliance would be achieved.

Regulation 15: Staffing

Improvements were required in the staffing arrangements to ensure continuity of care for residents at all times.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The maintenance of training records required improvements to ensure that there were no gaps in the documentation for all staff working in the centre. In addition, the training matrix required review to ensure that all staff working in the centre were included on this record.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required in the local and provider auditing systems to ensure effective oversight and monitoring of the centre with regards to staffing, staff training records and premises. In addition, improvements were required to ensure that all residents' personal needs were clearly documented and appropriate plans developed.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge ensured that all notifications as required under the regulations were notified to the Chief Inspector of Social Services.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints procedure in place which included the procedure for the appeals process. A review of recent complaints in the centre demonstrated that complaints were identified, taken seriously and followed up in line with the organisation's policy and procedures.

Judgment: Compliant

Quality and safety

Overall the inspector found that residents were provided with care and support in line with their assessed needs, and that residents' health and welfare were promoted. However, as mentioned previously one resident informed the inspector that they did not want to live in the centre, and said that they would like to live with others with whom they had more in common. The inspector found that while the resident was supported with their general health and wellbeing, the lack of a timely

action plan in supporting the resident with this request could impact their quality of care.

Residents had assessments completed on their health, personal and social care needs. These assessments informed the development of personal care plans to support with the identified needs. The plans in place were found to be comprehensive and kept under review. In general the documentation was well maintained, clear and up-to-date. However there was an inconsistency in the documentation for two residents' support plans relating to assessed health needs. This was addressed on the day, when it was brought to the attention of the management team.

In addition, one resident's assessment of need and personal plan had not been updated to reflect a personal and social care need that had been identified through a compatibility assessment in June 2021, and which the resident also spoke to the inspector about. The resident mentioned to the inspector several times throughout the course of the inspection their wishes with regard to their future living arrangements. While the person in charge spoke about an action that was due to occur prior to a COVID 19 outbreak, which would commence the process of supporting the resident with this; there was no clear, time bound plan developed since the identification of this compatibility issue in June 2021. At the feedback meeting at the end of the inspection, the management team spoke about de-congregation plans for the overall campus and stated that this resident would be prioritised.

Some residents living in Dreenan had complex healthcare needs and required high staff supports. Residents' care and support plans were found to be kept under regular review and residents' assessed needs with regard to their physical health were found to be well supported. Residents had access to allied healthcare professionals and were facilitated to attend relevant healthcare appointments and supported to avail of vaccine programmes in line with their wishes. On the day of inspection, the inspector observed staff following up with allied healthcare professionals to ensure that residents' wellbeing was promoted. Residents had end of life care plans as appropriate, and which were developed with support of their family members.

The premises in Dreenan was found to be bright and warm, with soft furnishings and personal photographs on display which created a relaxing and homely atmosphere. Residents had their own bedrooms, which were found to be personalised and decorated in line with their known preferences. An action relating to kitchen accessibility for wheelchair users arising from the last HIQA inspection had not yet been addressed. The action was due to be completed by the end of March 2022, as detailed on the compliance plan; however the inspector was informed that this completion date would not be met as the planning process was still in progress. While the home was generally in a good state of repair, it was found that the door frame surrounding the kitchen door leading to the hallway was damaged. When this was brought to the attention of the person in charge, they followed up with the relevant maintenance personnel who came to review it that day. The inspector was informed the day after inspection that this issue was

addressed.

Safeguarding of residents was promoted through discussion at meetings about safeguarding, the development of safeguarding plans as required, and the implementation of the policy and procedures for safeguarding vulnerable adults. An overarching safeguarding plan was in place for residents which identified potential safeguarding risks and how to mitigate and respond to this. Residents had access to advocacy services and therapeutic supports as required. Each resident had a comprehensive intimate and personal care plan which outlined their individual preferences, areas of independence and areas where supports were required.

While main meals were still being received from a centralised kitchen on the campus, residents were offered choices in these meals and were supported to purchase items from the supermarket to increase the availability of alternative meal options. One resident spoke about their favourite meal, and spoke about how they can buy items from the shop, some of which they chose to keep in their bedroom. Regular house meetings occurred, where choices of meals and activities were offered. It was noted that for non-verbal residents, that the use of a technological device to display photographs was used to support them with making choices. The meeting notes included about how staff members recognised how residents indicated their preferences, and it was noted that residents' choices were respected.

Residents who required supports with behaviours of concern had support plans in place that had a multidisciplinary input. A sample of plans reviewed demonstrated that they were comprehensive and clearly outlined descriptions of behaviours, triggers to behaviours and how to best support residents. Crisis management plans were developed where required, to guide staff on how to support residents when behaviours could not be managed through the strategies outlined in the behaviour support plan. A review of incidents that occurred in the centre demonstrated that an unplanned physical intervention was recently utilised for one resident in response to risks during behaviours of concern. This intervention was not included as part of the resident's individual crisis management plan, instead the use of a PRN medicine (a medicine only taken as required) was documented as the first step in supporting the resident with these behaviours. However, this had not been used in this instance which meant that the plan was not effective when this level of risk occurred. While a multidisciplinary meeting was held within two weeks of this incident occurring and the person in charge reported that this incident was reviewed at this meeting, there was no documentary evidence that the incident was reviewed with regard to the effectiveness of the resident's individual support plan.

In general, the management of identified risks and the associated documented assessments were good. Individual and centre specific risks were identified, assessed and had control measures in place which were under regular review. A risk relating to access to Speech and Language Therapist (SALT) to support residents' individual communication needs had been escalated by the person in charge, and it was noted on the most recent QIP that this action was in progress. Some improvements were required, however, to ensure that the risk ratings of some risk assessments were reflective of the actual impact and likelihood of the risks, in line with the organisation’s procedures and risk matrix. For example, some risks were

risk rated as the impact of the risk being a '6'; however the provider's matrix only included ratings between '1' and '5'. This indicated a need for improvement in understanding the risk management procedures and to ensure that risks were reflective of the actual impact.

In summary, the inspector found that residents were supported in line with their assessed needs and that their health was promoted. However, the development of a clear and timely personal plan for one resident to meet a personal need was required. In addition, improvements in the premises, review of behavioural incidents and aspects of risk management were required. Improvements in these areas would further enhance the quality and safety of care provided.

Regulation 17: Premises

Actions to improve accessibility to the kitchen as identified in the inspection by HIQA in October 2021 remained outstanding. While a plan was in progress to address this, the agreed time-frame to ensure accessibility would not be achieved. In addition, some internal works on the kitchen door frame was identified by the inspector, and this was followed up by the person in charge when it was brought to their attention.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risks were found to be identified, assessed and the documented assessments included control measures to mitigate against the risks posed. One risk had been escalated to senior management in line with the organisation's procedures. However, some risk ratings for individual residents' assessments were not in line with the risk management procedure and associated matrix for rating risks.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

In general residents' health, personal and social care needs were assessed, with care and support plans developed. However, one personal and social care need for a resident had not been appropriately assessed and updated through their assessment of need. Therefore no clear, time-bound personal plan had been developed with the resident to support them with this need, which had been identified through a compatibility assessment eight months previously.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health and were facilitated to attend a range of allied healthcare professionals as required. Healthcare plans were comprehensive in nature and kept under regular review. Residents were supported with developing end-of-life plans, as appropriate, which included family involvement.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required supports with behaviours of concern had plans in place to support them. Restrictive practices were kept under regular review, and one resident spoke about a restrictive practice that was in place for them to support their safety. However, there was no documentary evidence that an unplanned physical intervention that was used on a resident due to risks posed at that time, was reviewed to assess the effectiveness of the plan in place and why the current plan in place was not effective at that time.

Judgment: Substantially compliant

Regulation 8: Protection

Residents' safety and protection were supported through the development and implementation of safeguarding plans and discussion about safeguarding at staff meetings. Staff spoken with were knowledgeable about measures required to mitigate against the risk of safeguarding incidents between residents. Residents had personal and intimate care plans in place which clearly detailed the supports required in this area.

Judgment: Compliant

Regulation 9: Residents' rights

While residents' main meals were still being provided from a centralised kitchen,

there was evidence in resident meeting notes that meal choices and alternative options were given. Resident meetings were held regularly where topics such as shopping, outings, meal options and advocacy were discussed. Residents were supported to access advocacy services as required.
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	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dreenan Ard Greine Court OSV-0005490

Inspection ID: MON-0034496

Date of inspection: 01/03/2022

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: 1. The Person in Charge in liaison with the Director of Nursing has completed a review of staff within the centre – Completion date: 05/04/22 2. The Person in Charge in liaison with the Director of Nursing has identified a staff member to fill the outstanding vacancy and they will be reassigned to Dreenan – Date for completion: 16/05/22 3. Whilst awaiting the reassignment of the above staff member regular agency staff are being utilised to back fill the vacancy – Completion date: 05/04/22	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The Person in charge has commenced a review of the training matrix to ensure that all regular HSE staff and agency staff working in the centre are included on the matrix. – Completion date: 30/04/22 2. The Person in charge will complete a review of the training matrix and identify any training needs on a monthly basis – Date for completion: 01/04/22	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Regional Director of Nursing in conjunction with the CNM3 for quality, risk and service user safety and persons in charge are currently undertaking a review of all audits in place - Date for completion: 30/04/22
2. Following completion of this review any improvements and actions identified will be implemented to ensure auditing systems that are in place are effective and robust – Date for completion: 31/05/22
3. The most up to date provider 6 monthly and annual review are now onsite and available within the centre – Completion date: 28/02/22
4. The Provider representative has developed a schedule to ensure that all 6 monthly and annual reviews are completed within the required time frames and reports are provided to the centre in a timely manner – Completion date: 31/01/22
5. The Person in Charge has reviewed the Quality Improvement Plan to include incompatibility issues and to ensure that it is reflective of all actions required within the centre - Completion date: 06/04/22
6. The HSE has engaged an architect to develop plans for the reconfiguration to the layout of the Centre. The proposed layout has been approved by the housing association. The HSE has approved the funding for these works and the HSE Estates Department will commence a tendering process in April 2022 with an anticipated completion date for the works is 31/12/22 – Date for completion: 31/12/22
7. The Person in charge has liaised with the sensory Occupational Therapists (OT) and the centre of nursing and midwifery education department to provide training identified via sensory OT assessments – Date for completion: 30/05/22

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The HSE has engaged an architect to develop plans for the reconfiguration to the layout of the Centre. The proposed layout has been approved by the housing association. The HSE has approved the funding for these works and the HSE Estates Department will commence a tendering process in April 2022 with an anticipated completion date for the works is 31/12/22 – Date for completion: 31/12/22

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 1. The Provider representative has developed a schedule to ensure that all 6 monthly and annual reviews are completed within the required time frames and reports are provided to the centre in a timely manner – Completion date: 31/01/22 2. The Person in Charge has reviewed the Quality Improvement Plan to include incompatibility issues and to ensure that it is reflective of all actions required within the centre - Completion date: 06/04/22 3. The Person in Charge has completed a review of all risk assessments and amendments have been made to ensure that they are reflective of the current status and are in line with the HSE risk management policy and ratings. Completion date: 02/03/22 4. The HSE has engaged an architect to develop plans for the reconfiguration to the layout of the Centre. The proposed layout has been approved by the housing association. The HSE has approved the funding for these works and the HSE Estates Department will commence a tendering process in April 2022 with an anticipated completion date for the works is 31/12/22 – Date for completion: 31/12/22 5. The person in charge has liaised with the sensory Occupational Therapists (OT) and the centre of nursing and midwifery education department provide training identified via sensory OT assessments – Date for completion: 30/05/22	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: 1. The Person in charge in liaison with the Director of Nursing and the Multi disciplinary team will continue to monitor the compatibility of all residents in this centre particularly in relation one priority resident.– Date for completion: 31/12/22 2. The incompatibility for one resident in particular is being reviewed via the decongregation process and the Person in Charge will ensure that this information is included in the residents personal plan and monitored via the Quality improvement plan – 06/04/22	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:	

1. The Person in Charge arranged an MDT for the 10/03/2022 for a Resident identified as requring intervention. – Completion date : 10/03/22
2. The person in Charge has developed an action plan following the MDT and this will be monitored via the Quality inprovement plan – 30/04/22
3. The Person in Charge in liasion with the MDT have reviewed the behaviour support plan and crisis intervention plan for the identified resident– Completion date 10/03/22
The person in charge will ensure that minutes of all MDT meetings are an accurate refelection of everything discussed at the meetings. – Completion date: 10/03/22

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	16/05/2022
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	30/04/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	31/12/2022

	state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/12/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2022
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	Substantially Compliant	Yellow	31/12/2022

	risk, including a system for responding to emergencies.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/12/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/12/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used,	Substantially Compliant	Yellow	30/04/2022

	such procedures are applied in accordance with national policy and evidence based practice.			