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:	Tus Nua
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	29 April 2022
Centre ID:	OSV-0008146
Fieldwork ID:	MON-0035001

About the designated centre

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

Tus Nua provides full-time residential care to three residents and part-time care to one resident. The centre is a newly constructed bungalow in a housing estate located on the edge of a large town. The centre provides care and support for persons with both mild and moderate Intellectual Disability, with additional medical and social care needs. Residents require low to medium support services in terms of residential care and are supported by a defined complement of staff which includes a Staff Nurse and Health Care Assistants under the supervision of a Clinical Nurse Manager 2. Health Care Assistants arrive on duty at 16.00hrs going off duty at 09.00hrs Monday to Friday. Health Care Assistants provide sleepover support at night. The Centre is staffed all day on Saturdays and Sundays. Residents are supported by Health Care Assistants during intervals of non-attendance to day services.

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
Friday 29 April 2022	10:30hrs to 16:40hrs	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, including a targeted inspection programme which took place over two weeks in January 2022 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection) and regulation 23 (Governance and management). The overview report of this review has been published on the HIQA website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. 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. At the time of the inspection, the provider's compliance plan was not due to come into effect until the end of May 2022 (regulation 8 and 23), and although some actions had already commenced, others were not due to occur until after the inspection.

This inspection was the first inspection of this centre by the Health Information and Quality Authority (HIQA). It was an unannounced inspection. Overall, the inspector found that residents in the centre were in receipt of a good service that supported them to be independent. However, improvement was required in the governance and management of the centre and the provision of information to staff in the form of training, behaviour support plans and risk assessments. This will be outlined in the next two sections of the report.

The centre was a modern, newly-built bungalow in a housing estate on the edge of a large town. Each resident had their own bedroom and en-suite bathroom with level access shower. In addition, there was a bright kitchen-dining room, sitting room and utility room for use by the residents. There was also a staff office, shared bathroom and numerous storage rooms in the centre. The house was warm and welcoming. The communal rooms were tastefully decorated with new, modern furniture and the centre was in very good structural repair. Some minor maintenance issues had been identified by the person in charge and had been reported to the maintenance department. Residents chose the furnishings for the communal rooms in the centre. They also chose their own furniture and furnishings for their bedrooms. The centre was personalised with the resident's own photographs. Outside, there were well-maintained flower beds and a private patio space. Residents had planted the flower beds and put in a bird-feeder. The person in charge reported that there were plans to install a garden shed and outdoor seating in the near future.

The inspector met with three residents on the day. They reported that they were

happy in their new home and that they felt safe there. They said that they had picked the décor in the house. Residents said that they liked their bedrooms, their new house and the staff. They reported that they would be comfortable raising any issues with staff. One resident named the person in charge and a senior manager as the people they would contact with a complaint. Residents talked about the activities that they enjoyed. They discussed upcoming plans for family occasions and holidays. On the day of inspection, residents left the centre in the evening to go on social outings. The inspector also had the opportunity to meet a family member of one resident. The family member was very complimentary about the service in the centre. They said that they had no concerns regarding the safety of their family member and that they were happy in the centre. They said that staff were caring and that they would be comfortable raising any issues or concerns with staff.

Staff were observed interacting with residents in a friendly and caring manner. Staff offered choices to residents in relation to their food and activities. They were knowledgeable of the residents' interests and preferences. Residents were comfortable chatting with staff and telling them about their day. Staff were quick to respond when residents requested assistance.

Residents in this centre were active participants in the running of the centre. Resident meetings were held weekly. Residents chose the weekly menu and were supported to buy groceries. Staff reported that residents enjoyed some household chores, like cooking, cleaning, gardening and laundry. Residents' possessions were respected. For example, one resident's laundry was folded but left in the utility room so that the resident could put it away in their room at their own choosing. This was in keeping with the resident's preference and supported their independence. Residents engaged in numerous activities within the centre and in the wider community. There was a bus available in the centre for residents' use. Residents could also walk to local shops and cafes.

Residents were supported to maintain contact with their family in line with their own preferences. Family members called to the centre on the day of inspection and residents frequently met family members for visits and outings. They could also make regular phone calls to their family and friends.

Overall, residents in this centre were supported to be independent and active participants in the running of the centre. They were happy in their new home and had a good quality of life.

The next two sections of the report present the findings 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 residents.

Capacity and capability

There were governance and management systems in the centre that provided broad oversight of the service. However, improvements were required in relation to staff training and auditing in the centre.

This was a new centre and residents had only moved there a few months prior to the inspection. Therefore, an annual review and a six-monthly audit had not yet been completed by the provider. The person in charge was aware that these were required under the regulations and reported that there were plans to carry them out at the appropriate times. The provider had a schedule of other audits that were due to be completed at different points throughout the year. Audits were scheduled to be completed monthly, quarterly, six-monthly or annually. On review, it was noted that most audits in the centre had been completed in line with the schedule. However, audits of staff files and audits regarding infection prevention and control had not been completed as scheduled. The person in charge reported that this was due to competing demands with their workload. It was noted that all audits were completed by the person in charge and had not been delegated to other staff to ensure that they were completed in time. However, the person in charge reported that training was scheduled in the near future for staff in the centre to complete environmental audits. It was also noted that audits did not capture issues that were identified on the day of inspection, specifically in relation to the administration of medication to support residents' behaviour. This will be discussed later in the report. In addition to the audits, the centre had a quality improvement plan that outlined areas for service improvement and target dates for their completion. The quality improvement plan was reviewed and updated monthly by the person in charge.

There were defined lines of management and accountability in the centre. A review of the staff roster showed that a named staff member was designated as shift leader for each shift. There was a roster of senior managers who were on-call and could be contacted out of hours. The person in charge received supervision from their line manager on a monthly basis. Meetings between persons in charge of designated centres in Co. Donegal occurred on a fortnightly basis. The meetings had a set agenda that included issues relating to service delivery, auditing in the centre, training, review of incidents, safeguarding, and feedback from HIQA inspections. In addition, the person in charge reported that meetings occurred between the persons in charge and the service manager in South Donegal. These meetings were in line with the compliance plan that was submitted by the HSE following the programme of targeted inspections in January 2022.

Staffing in the centre was adequate to meet the assessed needs of residents. There was flexibility in the rostering system that allowed additional staff to be on duty to support residents when they did not attend their day services. The centre received nursing support from the person in charge and was staffed by healthcare assistants. This was appropriate to meet the assessed needs of residents.

A review of the training matrix, that outlines staff mandatory training, found that significant improvement was required in this area. While all staff were fully up to date on training in some areas, for example, fire safety, there were significant gaps in staff training in relation to infection prevention and control, cardiopulmonary resuscitation and human rights-based approach to care. Staff had received online

training in managing behaviour that is challenging and were scheduled to receive in-person training in the coming months.

The complaints procedure in the centre was reviewed. The centre had a complaints protocol. This was not on display in the centre when the inspector arrived. However, this was addressed on the day of inspection by the person in charge. The complaints officer's contact information was on display and complaints were audited quarterly. As outlined above, residents and family members reported that they would feel comfortable making a complaint if an issue arose.

Residents had written agreements in place that outlined their terms of residency. The written agreements gave information on the fees and charges that would be the responsibility of the resident. The care and support that the residents would receive was outlined in the agreement. The agreement was signed by the resident and a representative of the provider.

Overall, it was noted that the provider had systems in place to oversee the quality of service delivered in the centre. However, gaps in auditing and significant gaps in staff training require improvement as this could negatively impact on the quality and safety of the service delivered to residents.

Regulation 15: Staffing

The number and skill-mix of staff were adequate to meet the assessed needs of residents. There was flexibility in the rostering of staff to ensure that the needs of residents could be met effectively. Staff were familiar to the residents. There was a planned and actual staff rota available for review on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified a number of modules of mandatory staff training. Three members of staff were all found to require training in eight different modules. There were no definitive plans in place to address this training gap.

Judgment: Not compliant

Regulation 23: Governance and management

There were clearly defined management structures in the centre and lines of

escalation. Information sharing was facilitated by regular supervision of the person in charge and management team meetings. The provider had identified a number of audits that should be conducted in the centre and a quality improvement plan was in place. However, it was noted that two audits in the last quarter had not been completed in line with this schedule. Audit tools were not sufficient in all cases to identify areas of service improvement. In addition, oversight in relation to staff training, risk management and review of residents' plans required improvement.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Residents had a written agreement with the provider that outlined the terms of residency. The fees and charges that were the responsibility of the resident had been outlined in the agreement. The care and support that the residents would receive were detailed in the agreement.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints protocol in the centre. This was on display in the centre. The contact details of the complaints officer and advocacy service were on display in the centre. Complaints were routinely audited.

Judgment: Compliant

Quality and safety

Residents in this centre enjoyed a good quality of life and were safe in their home. However, significant improvement was required regarding residents' personal plans, risk management, the management of behaviours of concern, and the protection of residents from the risk of infection. In addition, some improvement was required in relation to the planning of evacuation of residents in the event of a fire.

Residents were protected from abuse in this centre. Staff training was up to date in safeguarding vulnerable adults. Contact information for the designated officer was on display in the centre. Quarterly safeguarding audits were completed in the centre. This audit examined documentation in relation to safeguarding, staff training and knowledge, review of restrictive practices, review of safeguarding plans and the

physical environment of the centre. On the day of inspection, there were no open safeguarding issues and no adverse incidents had occurred since the centre opened. As the residents in the centre had not all lived together previously, the provider had taken steps to ensure that residents were compatible. Compatibility assessments were completed with residents and there was input from the multidisciplinary team regarding the transition of residents to this centre. The safeguarding and protection team were included in this multidisciplinary review. Residents were also consulted on the move to the new centre and consulted about their new house mates. Intimate care plans had been developed for residents.

Residents' individual assessments and personal plans were reviewed. Residents were supported to develop goals in relation to their personal and social needs. The residents' preferences and dislikes were identified. From this, long-term goals were developed with the resident and there was evidence that these goals were reviewed and progressed. An individual assessment was completed with residents since they moved to their new centre. The assessment identified the residents' needs and gave an overview of the necessary care plans to support residents with those needs. The care plans gave clear guidance to staff on how to support residents. However, some plans had not been updated since the residents moved to the new centre. Some plans were not updated in line with the targets set out by the provider. For example, one resident's care plan in relation to tissue viability was due for review in October 2021, but had not occurred on the day of inspection. In addition, there was conflicting information in some sections of the plan. For example, one resident's care plan stated that they required a 'minced-moist' diet, but in another section it stated that their diet should be of a 'soft' consistency.

Residents' care plans also included their individual risk assessments. The assessments identified risks to the residents and outlined the control measures that should be implemented to reduce the risk. Some risk assessments had not been updated since the residents moved to their new home. Guidance and control measures in the risk assessments were not always up to date. For example, one risk assessment relating to the possibility of a resident contracting COVID-19 during a visit to family had not been reviewed since July 2021. It contained control measures that were not in line with current public health advice. In addition to individual risks to residents, the person in charge maintained a risk register in the centre that identified risks to residents, staff, visitors and the service as a whole. Again, these assessments identified the necessary measures that should be implemented to reduce risks in the centre.

A number of risk assessments related to the management of behaviour that is challenging. The control measures in these assessments outlined that staff had received training and that incidents should be recorded and reported to the person in charge. The risk assessments and residents' care plans did not provide guidance to staff on how to support residents manage their behaviour. Residents did not have any specific behaviour support plans. Therefore, there was no information for staff outlining the specific behaviours of concern, how to support the resident to remain calm and how to support the resident if they became anxious or agitated. A protocol for the administration of medication to help a resident manage their behaviour was documented in one care plan. This protocol did not give clear information on the

behaviours that would warrant the administration of the medication. The plan indicated that two doses could be given in a 24 hour period. However, there was no guidance on the recommended time between doses and what behaviours would warrant the administration of a second dose. The person in charge reported that a copy of the protocol was kept in another nearby designated centre as there was nursing support available in that centre. Staff could contact nurses from that centre to support them with this medication if required. However, this was not recorded on the medication protocol. An audit of this specific medication was completed by the person in charge every month since the opening of the centre. However, this audit only recorded that the medication had not been administered. It did not identify the shortcomings in the protocol itself, indicating that the audit tool was not effective at detecting areas requiring service improvement. Of note, there were no recorded adverse incidents or times where residents' displayed behaviour that is challenging since the centre opened.

As outlined above, the centre itself was a very pleasant building and suited to the residents' needs. The centre was fully accessible with level access throughout. Residents had adequate communal and private space. The bedrooms were of a suitable size and there was adequate storage for the residents' personal possessions. Each resident had their own bedroom and en-suite bathroom with level access shower. The centre was in very good structural and decorative repair. The rooms were fitted with fire doors throughout the centre. A review of fire safety records in the centre found that the fire detection and alarm system was routinely inspected by an external fire company. Fire drills were completed at different times and under varying conditions. There was evidence that learning from fire drills was recorded and addressed in the centre. Fire safety was discussed at resident meetings. Residents had individual evacuation plans with information for staff on how to support residents evacuate the centre in the event of a fire. There was also an evacuation plan for the centre that guided staff on how to support residents should they need to leave the centre in the event of an emergency. However, improvement was required in relation to this plan, specifically in relation to an evacuation at night when only one member of staff was on duty. Although residents were very independent, it was identified that they may require verbal prompts to evacuate the building. However, the centre's evacuation plan did not provide sufficient details to guide staff on how to support more than one resident evacuate in the event of a fire. In addition, the fire containment system divided the centre into zones. This had not been included in the centre's fire evacuation plan.

There were some good practices in this centre in relation to the protection of residents from the risk of infection. Staff completed a safety pause at the start of each shift to ensure they were hand hygiene ready and not displaying symptoms of COVID-19. Visitors to the centre were directed to complete temperature checks and symptom checks for COVID-19. There was a hand sanitisation station at the entrance to the centre and a separate hand hygiene sink in the kitchen. However, it was noted that hand towel dispensers had not been placed at sinks in communal rooms, including at the hand hygiene sink in the kitchen. In some cases, paper hand towels were stored on ledges next to the sink but this was not in keeping with best practice. This meant that hand hygiene could not be effectively completed at these sinks by staff or residents. In addition, pedal bins were not located at hand hygiene

points in the centre. As outlined previously, staff training in infection prevention and control, including hand hygiene, standard precautions, and respiratory etiquette, was out of date for three staff. Infection prevention and control audits had not been completed in the centre in line with the provider's schedule.

In summary, this was a pleasant home where residents were supported to be independent and included as active participants in the running of the centre. Residents had a good quality of life in this centre. However, actions were needed in relation to risk management, behaviour support plans, fire precautions, personal plans, and infection prevention and control.

Regulation 17: Premises

The centre was suited to the needs of the residents. Residents had adequate private and communal space to allow them to spend time together or alone, as they so wished. There was adequate storage for residents' possessions. The centre was equipped with the necessary facilities to meet the residents' needs. The centre was in very good structural and decorative repair.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk register in the centre that identified risks to the service and gave guidance on how to reduce the risks. In addition, residents had individual risk assessments. However, not all risk assessments had been updated since the residents moved to their new centre and therefore, may not have been reflective of the residents' current situation and needs.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were some good practices in relation to infection prevention and control in the centre. For example, staff and visitors completed symptom checks to protect residents from COVID-19. However, significant improvement was needed in relation to the provision of hand hygiene facilities, staff training in infection prevention and control, and auditing of infection prevention measures.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had taken steps to protect residents from the risk of fire. There were good systems in place for the detection and containment of fire. The fire alarm and emergency lighting system was routinely checked by an external fire company. However, improvement was required in relation to the arrangements for the evacuation of all residents from the centre in the event of a fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had completed an assessment of the health, personal and social care needs of the residents. Residents were included in setting their personal and social goals. Care plans were in place to provide guidance to staff on how to support the residents. However, a review of these plans found that a number of them had not been updated since the residents moved to their new centre. They also had not been updated in line with the provider's own timelines. It was also noted that there was some conflicting information contained within the care plans.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There was inadequate information available to guide staff on how to support residents with behaviour that is challenging. Risk assessments in this regard did not provide sufficient guidance to staff so that clear actions could be taken to support residents. There were no behaviour support plans in place to outline how staff could identify or prevent behaviour that is challenging and support residents manage their behaviour. Protocols for the administration of medication to support residents manage their behaviour were not sufficiently detailed. This created a risk that this medication could be administered inappropriately.

Judgment: Not compliant

Regulation 8: Protection

Staff were trained in the protection of residents from abuse. Safeguarding practices and documentation was regularly audited. The provider had ensured the compatibility of residents before they moved to their new centre. There were intimate care plans in place for residents. Incidents could be escalated to senior management and were regularly reviewed in the centre.
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	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tus Nua OSV-0008146

Inspection ID: MON-0035001

Date of inspection: 29/04/2022

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In order to come into compliance with this regulation the following actions are being taken: 1. A schedule has been developed to address all mandatory training requirements as follows: Manual Handling Training for two staff is scheduled for June 16th & 24th 2022. Hand Hygiene for two staff was completed on May 13th & 15th 2022. Standard precaution training for one staff was completed on June 15th 2022. Infection prevention control for one staff was completed on May 15th 2022.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to come into compliance with this regulation the following actions are being taken: 1. The two outstanding audits (Infection control audits & Personal plan audits) have been completed as per the audit schedule. 2. A review of audits currently utilised across designated centres is currently being undertaken. This is being lead out by the Regional Director of Nursing CHO1 in conjunction with CNM3s for Quality, Risk & Service User Safety CHO1. An assessment of training requirements in this area will also be carried out with a view to providing the necessary upskilling. 3. An 0.5 whole time equivalent staff nurse will be appointed to the centre to assist and support the Person in Charge. The recruitment of a Staff Nurse will take place in	

October pending graduation of Student Nurses.

4. In the interim period, until a staff nurse is appointed, The area co-ordinator will meet with the Person in charge on a monthly basis to provide oversight of training, risk management and review of personal plans.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to come into compliance with this regulation the following actions are being taken:

1. Individual Risk Assessments have been reviewed and updated to reflect resident's current living environment and needs in line with up to date public health advice.

2. Detailed Behaviour Support Plans will be put in place in conjunction with the Clinical Psychologist to ensure staff can identify and manage behavior that is challenging. The support plans also supports the residents to manage their behavior.

3. Medication administration protocols are being reviewed and updated to ensure staff are provided with clear information in relation to the administration of medication to support residents manage their behavior that is challenging.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
In order to come into compliance with this regulation the following actions are being taken:

1. Hand towel dispensers will been erected at all sinks in communal areas in the centre.

2. Pedal bins have been placed at hand hygiene points throughout the centre.

3. A training schedule has been put in place for staff working in the centre in relation to Hand Hygiene, Standard Precautions and Respiratory etiquette as follows:

Hand Hygiene for two staff completed on May 14th & 15th 2022
Standard Precautions completed on May 15th 2022
Respiratory Etiquette completed on May 15th 2022

4. Infection Prevention and Control audits have been completed on June 8th 2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

In order to come into compliance with this regulation the following actions will or are being taken:

1. The centres evacuation plan has been reviewed and updated to identify the zones within the centre and to provide specific information for staff in relation to the evacuation of all residents from the centre in the event of a fire.

2. The evacuation plan will be discussed with staff during the next governance meeting at the centre which is scheduled for June 21st 2022. Staff have been alerted to the reviewed evacuation plan via the centres communication book and the Person in charge has discussed this with staff on duty in the centre.

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:
In order to come into compliance with this regulation the following actions have been taken:

1. All residents care plans will be reviewed and updated to ensure that information contained within is up to date, reflects their current living arrangements is clear and consistent for staff.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In order to come into compliance with this regulation the following actions are being taken:

1. Detailed Behaviour Support Plans will be put in place in conjunction with the Clinical Psychologist to ensure staff can identify and manage behavior that is challenging. The support plans will also supports the residents to manage their behavior.

2. Medication administration protocols are being reviewed and updated to ensure staff are provided with clear information in relation to the administration of medication to support residents manage their behavior that is challenging.

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 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.	Not Compliant	Orange	24/06/2022
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	30/11/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	29/06/2022

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	08/06/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	21/06/2022
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	Substantially Compliant	Yellow	30/06/2022

	circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/06/2022