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:	Finnside
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	29 March 2022 & 30 March 2022
Centre ID:	OSV-0008153
Fieldwork ID:	MON-0035403

About the designated centre

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

Finnside designated centre is located within a small campus setting which contains six other designated centres operated by the provider. Finnside can provide full-time residential care and support for up to four residents, both male and female. Finnside consists of two sitting rooms, one of which has patio doors with access to the garden, a dining-room, a visitor's room, kitchen, Jacuzzi bathroom, three shower rooms, two en-suite bedrooms and four single bedrooms. A laundry room is available where each resident, if they choose, can participate in their laundry. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. There is also transport available for residents to access community outings. Residents are supported by a staff team of nurses and healthcare assistants who provide 24 hour support, with two waking night staff in place each night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 29 March 2022	13:50hrs to 18:45hrs	Angela McCormack	Lead
Wednesday 30 March 2022	09:40hrs to 15:00hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

There were three residents living in Finnside at the time of inspection. The inspector met with all three residents and observed daily activities and interactions throughout the course of the inspection. Finnside home was spacious and had ample communal spaces for residents to enjoy. Residents appeared comfortable in their home and with staff supporting them.

Residents were observed relaxing, playing table top games and having meals throughout the inspection. On the first afternoon of the inspection, the inspector met briefly with two residents. One resident was reported to be resting in bed, and the inspector did not get the opportunity to meet with the resident until the following day. Finnside house had experienced the death of three residents over the past year, and staff members and the management team described supports being provided to residents. Residents were supported to understand and grieve the loss of their peers, through access to MDT for therapeutic supports and through the involvement in meaningful opportunities to ensure the memories of their deceased peers were respected. The inspector was informed, and later observed, a member of the multidisciplinary team (MDT) at the centre meeting with residents as part of the planned therapeutic supports provided.

Finnside home was clean, bright and spacious. Each resident had their own bedrooms, which were decorated in line with residents' personal tastes. There were two large sitting-rooms, a dining-room and smaller sitting room for residents to enjoy. There was a communal bathroom which had an accessible bath, and also a bathroom which contained a level access shower for residents. There was a memory table in the hallway which contained framed photographs and poems about the residents who had recently died. The garden area was accessible through patio doors leading from the dining-room and the garden was observed to be nicely decorated and maintained. It included potted flowers, a bird table, and colourful ornaments. It also included a tree that had recently been planted in memory of one of the deceased residents. On the day of inspection some residents were involved in planting sunflowers in memory of their deceased housemates. This was something that was noted to have been discussed and agreed at a recent residents' meeting.

All residents living in Finnside had communication needs and the inspector was informed that referrals for speech and language therapy (SALT) assessments had been made. This need was outstanding for all residents. Staff supporting residents helped them to communicate with the inspector in line with their wishes and through the means of communication as outlined in their personal plans. The inspector spoke with one resident through their preferred communication means, and they talked about what they enjoyed; such as country music and going for bus drives. They spoke about how they were going to visit family soon and how they had recently attended a parade in town. When asked if the resident liked living at the centre, they expressed that they did. Another resident was supported to speak about their life and spoke about how they liked a particular beverage and going on

the bus. However, it was observed on the first evening that one resident was expressing a choice in relation to an activity that they wanted to do and it was observed that staff were unsure about what exactly the resident was requesting. While staff were observed to be very responsive and endeavouring to understand what the resident was expressing, an assessment of communication needs to further support the resident express their choices would help to ensure their will and preference was fully heard.

A review of documentation; including the annual review of the centre, residents' meetings, care plans and daily records were completed to further review the lived experience of residents. The inspector also spoke with a number of staff who described residents' likes and supports and were knowledgeable about supports described in the support plans. Feedback from residents' families as part of the annual review were noted to be complimentary about the service and supports provided to their family member.

Residents were reported to enjoy activities such as going to music concerts, gardening, going for bus drives, going to the beach and attending music sessions in an external day service location. Each resident was supported to develop a person centred plan, where they were supported to identify goals for the future. However, it was noted that the achievement of some residents' goals were not done in a timely manner and some of the goals were generic in nature and involved day-to-day activities such as resting in bed during the day. This required improvements to ensure that where choices were made about goals for the future, that these were achieved in a timely manner.

Overall residents were observed to be comfortable and content in their home and staff were observed to be treating residents with dignity and respect and in line with their needs. The following sections of the report outline the management arrangements and how this impacts on the quality and safety of care.

Capacity and capability

This centre was one of seven designated centres based on a campus in Co. Donegal. This inspection was carried out to follow up on actions since the last inspection by the Health Information and Quality Authority (HIQA) in September 2021. The centre previously formed part of 'Railway View and Finnside' designated centre. The provider submitted an application to remove this centre from 'Railway View, and to register the centre as a standalone centre. This occurred in December 2021.

As part of the monitoring of this centre and other designated centres located on the Ard Greine campus, the provider was required to submit monthly updates on a quality improvement plan to HIQA, since April 2021. Some actions included on this plan were also reviewed as part of this inspection.

Overall, the inspector found that there were improvements in the governance and management of Finnside, which led to improved outcomes for residents. However, further improvements were required to achieve full compliance with the regulations and to further enhance the quality of care and support provided to residents. Improvements were required in a number of areas including: access to communication assessments, staffing arrangements, staff training, fire safety, premises, safeguarding plans and in ensuring the achievement of residents' personal goals. These will be discussed in more detail throughout the report.

A new local management team had commenced in February 2022. This included a new person in charge and a clinical nurse manager 1 (CNM1). This layer of management (CNM1) was part of the provider's quality improvement plan to strengthen and improve the governance arrangements for the centre. The CNM1's role included delegated tasks to support the person in charge with the operational management of the designated centre. The person in charge was on leave on the days of inspection, however the CNM1 was available throughout the inspection. They appeared knowledgeable about residents' needs and were responsive to any actions identified to improve the quality of care in the centre.

The centre's current and previous month's rota were reviewed. The maintenance of the rota required improvements to ensure that it was clear with regard to the times recorded and abbreviations of staff grades. For example; there was a mix of 12 hour and 24 hour clock used and an abbreviation used for a staff member that was not clearly explained. In addition, the contingency arrangements for staffing required improvements as on both days of the inspection a staff nurse was absent meaning that the CNM1 had to work one of the days, which could impact on their management roles and responsibilities. It was noted that a risk assessment had recently been completed by the person in charge to assess the risks associated with the local management team having to cover for staff absences on the campus, and how this could impact on the governance of the centre. This risk had been rated as a 'high' risk and had recently been escalated to the Director of Nursing (DON) and was under review at the time of inspection.

Staff training required improvements. Training records and the training matrix were reviewed. The training records for agency staff were not available for review which meant that the inspector could not confirm that all staff had completed mandatory training. Training was outstanding for some staff in Supporting Sexuality in Supported settings and the inspector was informed that this was due to be completed in the coming days. In addition, some mandatory and refresher training were found to be required in donning and doffing Personal and Protective Equipment (PPE), manual handling, cardiopulmonary resuscitation (CPR) and infection prevention and control (IPC) - respiratory hygiene.

Staff were supported through annual 'personal achievement planning' meetings. These meetings were outstanding for four staff. The inspector was informed that a plan was in place to complete these meetings by the management team. In addition, the new management team had a plan in place to ensure regular team meetings occurred where all staff had opportunities to attend. Staff spoken with during the inspection said that they felt supported and one staff complimented the

staff team and described how they felt supported when they first commenced working in Finnside.

Regular audits occurred in the centre as part of the monitoring and oversight; however these required improvements to ensure that they were effective and brought about improvements.

The provider completed an unannounced provider audit in December in 2021 which incorporated the other location which this centre had previously been part of. However, this audit failed to review the progress of some actions from the last HIQA inspection in September 2021. In particular, fire safety which had been an issue at the last HIQA inspection resulting in an urgent action being required, had not been reviewed by the provider. Also an action to improve the accessibility of the kitchen area which had been agreed with HIQA as part of the compliance plan, was not reviewed and therefore failed to identify that the action would not be met. While a number of actions in other areas had been identified by the provider to improve the quality and safety of care, the timeframe set out in which to achieve some of the actions were not timely. For example, an action identified the need to provide residents with a meaningful day; however this was set as due for completion by the end of April, some four months after this area for improvement was identified.

The local management team had developed a centre specific quality improvement plan (QIP) for this centre since its recent registration. This was found to be kept under review. The local management team developed an annual schedule for a range of local audits to be completed. This included audits in health and safety, finances, personal plans, restrictive practices, complaints and fire safety. However improvements were required to ensure more effective monitoring and to ensure that actions identified in audits were followed up in a timely manner. For example; there were gaps in the fire safety audits, and where some weekly checks had identified an issue with one fire door, this had not been resolved in a timely manner and the local management team were unsure as to the status of the issue. This was addressed by the CNM1 on the day, with the relevant personnel on site on the second day of inspection to address the issue. The management team spoke about how they could improve on this going forward.

A review of accidents and incidents that occurred in the centre over the past three months was completed by the inspector. It was found that the person in charge ensured that all notifications as required under the regulations were submitted to the Chief Inspector of Social Services.

In general, improvements were found in the ongoing monitoring and oversight of the centre to ensure that regulatory compliance could be achieved and sustained, which would enhance the quality of service provided to residents.

Regulation 15: Staffing

The contingency plans for staffing the centre when absences occurred did not promote continuity of care to residents. For example; on the days of inspection due to staff shortages, a staff nurse from another centre on the campus and the CNM1 was required to work in the centre to ensure the numbers of staff were appropriate to meet residents' assessed needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were gaps in the training documentation maintained, where some training records were not available for review. This related to agency staff who worked in the centre regularly. In addition, training was outstanding for some staff in PPE, IPC, CPR, Manual handling and SASS. The inspector was informed that training in SASS for the remaining staff was scheduled for the week of inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required in the local management and provider audits to ensure effective monitoring and oversight of the centre and to ensure that actions for improvement were effectively identified and completed in a timely manner to ensure a quality and safe service at all times.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the incidents that occurred in the centre demonstrated that all notifications were submitted to the Chief Inspector of Social Services as required in the regulations.

Judgment: Compliant

Quality and safety

Overall the inspector found that residents were consulted about the centre and provided with a homely environment. However, improvements were required in communication assessments to support with communication needs, improved accessibility to the kitchen, fire safety, safeguarding plans and ensuring that residents' personal goals were achieved in a timely manner.

Residents were supported to achieve the best possible health by being facilitated to attend allied healthcare professionals, such as General Practitioners, Chiropodists, and consultants, and national screening and vaccines programmes, as appropriate and in line with their expressed choices. Residents had end-of-life care plans developed where appropriate, and included residents and their advocates/family members.

Comprehensive assessments of need were completed to assess, personal, health and social care needs. Annual review meetings were held which included consultation with residents and their families. In addition, residents had personal planning meetings where they were supported to identify goals that they would like to achieve. A sample of these reviewed found that some of the goals were generic in nature and there was no time bound plan developed for chosen activities which meant that some were not achieved. For example, one resident had identified in December and January, a number of goals including that they would like to go to a concert, buy new shoes, do an art project and get a facial. However, none of these had been achieved some three months later and there was no clear plan for these to be achieved.

Residents had a range of care and support plans in place to guide staff in the supports required in areas relating to healthcare needs, behaviour related needs and personal and intimate care. These support plans were found to be comprehensive, up-to-date and included multidisciplinary input as relevant.

In general, residents had good access to multidisciplinary supports, such as behaviour specialists, psychologists, physiotherapists and occupational therapists. However, a need for speech and language assessments to aid with communication supports remained outstanding for residents. There was only one speech and language therapist available for all residents on the campus, and as this was based on a prioritisation system the residents in Finnside had not yet been assessed, despite referrals being made.

Residents' main meals were still being delivered from a centralised kitchen. However, it was noted in residents' meeting notes and through observations, that residents were supported with choices around alternative meal options. Residents were supported with accessing independent advocacy services and were consulted with choices through regular residents' meetings and the personal planning process. However, improvements in communication supports and in the achievement of personal goals were required to ensure that residents' choices about their lives were heard and followed up in a reasonable timeframe.

Safeguarding of residents was promoted through reviews of incidents, discussion at resident and staff meetings about safeguarding and the development of

safeguarding plans as required. In addition, residents had personal and intimate care plans which detailed how best to support them during personal care. Residents had overarching safeguarding plans in place which included details about safeguarding risks and about how to respond to any concerns. However, two plans required updating as they were not clear about what the specific safeguarding risks were. In addition, it was not clear if all the actions included on a safeguarding plan for one resident had been reviewed and actions completed. As part of the provider's quality improvement plan HIQA had been informed that compatibility assessments had been completed for all residents. However, there was a gap in documentation as one compatibility assessment was not available for review by the inspector, and which related to a resident whose behaviours were noted to impact on others at times.

The home was spacious and comfortable for the number of residents who lived at Finnside with a number of communal rooms for residents to enjoy. However, works to address the accessibility to the kitchen remained outstanding. The inspector was informed that plans were in progress, however the time-frame for end of March 2022 as previously agreed through the compliance plan from the last HIQA inspection, would not be achieved.

The risk management process was found to be good in Finnside. There was policy and procedure in place for risk management in addition to a centre specific safety statement and emergency plans. Centre specific risks and individual resident risks had been identified, assessed and risk rated. Where a risk was rated as 'high' in line with the organisation's policy and procedures this had been escalated to senior management for review. As noted previously, one risk relating to the absence of staff on the campus and how this impacted on the person in charge and CNM1 fulfilling their duties had been escalated to the DON, and was currently under review.

Fire safety had been not compliant on the last inspection by HIQA, and an urgent action was required on the day. Improvements were found to be required to ensure compliance with the regulations on this inspection also. There were gaps found in the auditing systems, with some audits not being completed as required and the location of the fire equipment was not clearly stated on the required documentation. This was addressed by the local management team when it was highlighted.

In addition, an issue had been identified regarding a fire door on a residents' bedroom on 14 February, and the most recent check the week of inspection found that the issue remained. It was not clear through documentation provided and through discussion with the CNM1 about what the plan was to address and resolve this issue. The CNM1 followed up with the relevant personnel on the day of inspection to resolve this issue.

Improvements were also required in fire drills to ensure that all residents could be safely evacuated under the scenario of when residents were in bed sleeping. All residents required some level of support at night-time, with some requiring staff to use evacuation sheets to ensure that they could be safely evacuated. There were two staff on duty each night, and it was noted as part of the fire policy that a staff

from a nearby centre could be called on to support when minimum staffing levels were in place. The centre evacuation plan was not clear on what role this additional staff played in supporting with the evacuation. This was addressed on the evening of the first day of inspection, with a simulated fire drill carried out and the emergency plan updated to ensure that it was clear about how to safely evacuate all residents under the scenario that they were in bed asleep and with the additional staff. The CNM1 assured the inspector that they would keep this under review and planned to carry out further simulated fire drills involving all staff to ensure that they had the knowledge to ensure a safe and timely evacuation under minimum staffing levels.

Overall, the quality and safety of care provided to residents had improved since the last inspection in September 2021. However, improvements were required in fire safety, accessible premises and in the achievement of residents' personal goals which would further enhance the safety of the care and support provided.

Regulation 10: Communication

Residents required supports with Communication and had 'Communication dictionaries' developed which outlined what particular words, gestures and behaviours meant and how to respond. However, the inspector was informed that residents who had been referred for professional supports with SALT had yet to be assessed. This assessment would further support residents to ensure that their preferred communication styles were understood at all times.

Judgment: Substantially compliant

Regulation 17: Premises

Actions relating to the accessibility to the kitchen for all residents remained outstanding. This was reported to be in the planning stages, therefore the issue remained despite the compliance plan provided by the provider in response to the HIQA inspection September 2021 saying that it would be addressed by the end of March 2022.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risks that occurred in the centre, and which related to residents' safety were identified, assessed and kept under review. Where risks identified were risk rated as

'high' in line with the provider's policy and procedures, these were escalated to senior management for review.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety management required improvements to ensure that the auditing systems were robust in identifying and responding to fire safety issues and to ensure that all residents could be safely evacuated under minimum staffing levels.

- It was not clear on the relevant documentation about where the fire fighting equipment was located. This was addressed by the CNM1 by the end of the inspection.
- There were some gaps in the weekly checks for fire safety, with some weeks checks not being completed.
- There was not a timely response to address issues highlighted through audits relating to one fire door. This was highlighted on 14/02/2022, and on subsequent dates; however the issue was only addressed on the day of inspection.
- The centre evacuation plan/Fire policy required review to ensure that it was clear and fit for purpose. This was addressed by the end of inspection, with the CNM1 reporting that a further review will be completed following further fire drills.
- A fire drill under minimum staffing levels and under the scenario were all residents were in bed had not been completed. This was addressed by the end of inspection, whereby the CNM1 carried out a simulated fire drill and a review of same and further action had been identified by the CNM1 to assure that all residents could be safely evacuated.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal plans had been developed with residents. In addition, residents were supported to identify a person-centred plan for the future. However, it was found that some personal goals were generic and related to daily activities, and some goals detailed in the plan were not achieved in a timely manner.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health by being facilitated to attend a range of healthcare appointments and they were supported to access national screening programmes and vaccines as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required supports with behaviours of concern had comprehensive support plans in place which included input from the relevant multidisciplinary team members.

Judgment: Compliant

Regulation 8: Protection

Improvements were required in the documentation of some safeguarding plans to ensure that they provided clear information about any identified safeguarding risks. Compatibility assessments relating to residents who's behaviours were noted to impact on others at times, were not available for review.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were consulted about the centre and kept informed of relevant information through regular residents' meetings. While main meals were delivered from the campus centralised kitchen, there was evidence that residents were offered a choice in meals, and could also choose alternative options to what was available at the kitchen. 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
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Finnside OSV-0008153

Inspection ID: MON-0035403

Date of inspection: 29/03/2022 & 30/03/2022

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: 22/04/22 2. The Person in Charge in liaison with the Director of Nursing has identified staff members for permanent relocation to Finnside – Date for completion: 31/05/22 3. Whilst awaiting the reassignment of the above staff member regular agency staff are being utilised to back fill the vacancy – Completion date: 22/04/22	
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/ Director of Nursing has completed a further review of the training matrix to identify outstanding training requirements – Completion date: 28/04/22 2. All staff within the centre have now completed the training on supporting adults sexuality in residential settings – Completion date: 22/04/22 3. The Person in Charge will schedule all staff for outstanding CPR and these will be completed by the end of June 2022 – Date for Completion : 30/06/22 4. The Person in Charge has advised staff of all outstanding training on HSELAND ie Infection control, PPE and all other mandatory training that they require to update and complete by end of June 2022 – Date for completion 30/06/22 5. The Person in charge has commenced developing a training matrix for the regular agency staff that are working within the centre – Date for completion: 31/05/22 6. The centre's training matrix will be kept under monthly review to ensure compliance with all training identified – Date for completion: 29/04/2022.	

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 utilised across the service. Following completion of this review a decision will be taken in relation to specific audits for use within the centre and training for staff undertaking audits. Date for completion: 31/05/22
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 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
4. The Provider representative will ensure that completion dates for actions in the 6 monthly and annual reviews are within a realistic timeframe– Completion date: 22/04/22
5. The Person in Charge has reviewed the audits for Q4 2021 and Quarter 1 2022 to ensure that all audits are fully completed – Completion date: 22/04/22

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
1. The Person in Charge has liaised with the Speech and Language therapist (SALT) in relation to agree dates for the assessment of residents – Date for completion: 05/05/22

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 2 centres initially. Once these centres have been completed Finnside will be in the 2nd phase for the reconfiguration – Date for completion: 30/06/2023
2. The Person in charge continues to ensure that residents can participate in activities such as making snacks and baking in an alternative area within the centre – Completion date: 29/09/2021

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The Person in charge has reviewed the documentation and fire book to ensure that it clearly states where all fire fighting equipment is located – Date completed 29/03/22
2. The Person in chrage has reviewed the fire book and documentation to ensure all checks are being completed as per the schedule and that issues are addressed in a timely manner Date completed: 08/04/22
3. The Person in charge has ensured that a fire drill has been undertaken with minimum staffing levels and maximum occupancy when residents are in bed has been completed via simulation. Completion date: 29/03/22
4. The Person in Charge has updated the evacuation/fire policy has been updated to ensure that it is clear and fit for purpose. Completion date: 30/03/22

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 named nurses have commenced a review of PCP goal for all residents to ensure that they are meaningful and individualised. Date for Completion: 15/05/22
2. The Person in charge will carry out a monthly review of the PCP goals to ensure that the goals are being achieved within the agreed timeframe with residents. Date for completion: 31/05/22

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Person in Charge in liaison with the safeguarding and protection team have commenced a further review of the overarching safeguarding plans. Date for completion: 28/04/22
2. The person in charge has ensured that compatibility assessments are accessible in the residents files. Completion date: 05/04/22

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	05/05/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/05/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/05/2022

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	30/06/2022
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	30/06/2023
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	31/05/2022

Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	08/04/2022
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	08/04/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	08/04/2022
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/05/2022

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	08/04/2022