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: | Ballytrim House |
| Name of provider: | Health Service Executive |
| Address of centre: | Donegal |
| Type of inspection: | Unannounced |
| Date of inspection: | 24 April 2025 |
| Centre ID: | OSV-0002523 |
| Fieldwork ID: | MON-0046605 |

## About the designated centre

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

Ballytrim House provides residential care and support to adults with a disability. The designated centre comprises an seven bedded one-storey building located in a residential housing estate in a small town. Residents living at the centre have access to communal facilities such as sitting rooms, a sensory room, dining room, kitchen and outdoor area. Each resident has their own bedroom with en-suite bathroom. The centre also has additional communal bathroom and toilet facilities. Ballytrim House is located close to local amenities such as shops, public houses and cafes. There are three vehicles available which enable residents to access other amenities in the surrounding area such as swimming pools and other leisure facilities. Residents are supported night and day by a staff team of both nursing and care staff.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Number of residents on the date of inspection: | 7 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Thursday 24 April 2025 | 09:35hrs to 16:10hrs | Alanna Ní Mhíocháin | Lead |
| Thursday 24 April 2025 | 09:35hrs to 16:10hrs | Catherine Glynn | Support |

## What residents told us and what inspectors observed

This inspection was an unannounced focused inspection to review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and the National Standards for Adult Safeguarding (2019). It followed a regulatory notice issued by the Chief Inspector of Social Services in June 2024 in which the safeguarding of residents was outlined as one of the most important responsibilities of a designated centre and fundamental to the provision of high quality care and support. Furthermore, that safeguarding is more than the prevention of abuse, but a holistic approach that promotes people's human rights and empowers them to exercise choice and control over their lives.

Significant failings in relation to the governance and management of this service were identified on inspection. This created significant risks to residents, impacted on their quality of life and their human rights. Inspectors were not assured that residents were kept safe in this centre. Inspectors found significant risk to one resident in relation to their living arrangements. This resulted in the issuing of an urgent compliance plan the day after the inspection. This required the provider to respond to the Chief Inspector of Social Services with a timebound plan for the resident to move to the part of the centre that was suited to their needs. The provider responded that the resident would move to their new bedroom by 10 May 2025.

The centre was registered to accommodate seven residents. On the day of inspection, seven residents were living in the centre. There was a plan for three residents to move out of Ballytrim House to a new centre. This plan had been in place for a number of years. However, the move to the new centre had been delayed on a number of occasions. On the day of inspection, the new centre was registered. The provider informed inspectors that they were still in the process of recruiting staff for the new centre. They intended for the three residents to move out in July 2025. A plan for two residents to swap bedrooms and living rooms within Ballytrim House was originally linked to the overall decongregation plan. However, given the significant risk to one resident's health due to their unsuitable living arrangements, the provider had planned to proceed with this transfer within Ballytrim House prior to the other residents moving out to the new centre. Though this had been identified as an urgent need, the provider had not yet completed this transfer on the day of inspection. This was despite the fact that the refurbished living arrangements had been in place in Ballytrim House since April 2024. In addition, the provider did not have a definite plan for this transfer to occur.

The centre was a very large building in a housing estate at the edge of a rural town. The centre was all on the ground floor and was built in a U-shape. Each resident had their own bedroom with an en-suite bathroom. In addition, the centre had sitting rooms, a room with sensory equipment, a large dining room and a large kitchen. This kitchen was an industrial kitchen and the residents' main meals were

not prepared there. The person in charge reported that main meals were delivered to the centre daily. There was also a laundry room, staff offices, bathrooms and store rooms.

One section of the building was separated from the rest by a magnetically locked door. One resident resided in this section of the building. This arrangement had been put in place to reduce negative interactions between residents and to reduce the resident's exposure to noise as this caused them distress. This section of the building consisted of the resident's bedroom with en-suite bathroom, a sitting room, a dining room and a staff sitting room. This section of the building was located near the kitchen and dining room. The resident had their own entrance door so that they did not have to go through the main building when coming and going to the centre. On the opposite side of the building, there were four rooms that had padding on the walls and doors. The intention was for the resident to move to this section of the building as they required these accommodations to reduce risks to their health. Another resident was living in this section of the building on the day of inspection, though they did not require the padding. This will be discussed further in the report.

The centre was clean and tidy. Residents' bedrooms were decorated in different styles and colours in line with their tastes. However, inspectors noted that there were areas within the centre that required improvement. One resident's bathroom had damage to the walls. Inspectors noted broken covers on radiators in one resident's bedroom. Staff reported that the some of the sensory equipment was damaged and needed to be replaced.

The inspectors met with four of the seven residents on the day of inspection. One resident brought inspectors to view their bedroom and sitting room. They spoke about their plans to get their nails painted that day. Residents were busy coming and going from the centre throughout the day.

In addition to the person in charge, the inspectors met with four members of staff who worked in the centre. A member of senior management was also in the centre for a period of time during the inspection. Staff were knowledgeable on the needs of residents, particularly in relation to the supports they needed to manage their behaviour. Staff knew what steps to follow should a safeguarding incident occur. They spoke about information sharing in the centre through handover meetings between staff on a daily basis. Staff spoke about the supports they offered residents in the centre and in the wider community.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affect the quality and safety of the service provided.

## Capacity and capability

Significant improvement was required in relation to the oversight of the service.

Staffing numbers were suited to the needs of residents, but improvement in staff training was required.

The governance and oversight arrangements in the centre were not effective. Some of the service improvement issues were identified by the provider. However, the systems to progress these issues, reduce risks and complete service improvement were not effective. This resulted in areas of known high-risk to residents remaining in place for extended periods of time. The provider had failed to act on recommendations from members of the multidisciplinary team in relation to behaviour support and supporting residents' communication.

The number and skill-mix of staff were suited to the needs of residents. There was an adequate number of staff on duty at all times to support the residents. Staff received training in areas that were relevant to the care and support of residents. However, not all staff had up to date training in all areas. For example, a quarter of staff required refresher training in managing behaviours of concern. This was an area of high need in this centre.

## Regulation 15: Staffing

The staffing arrangements in the centre were suited to the needs of residents.

The inspectors reviewed the rosters from 6 January 2025 to 11 May 2025 and found that the number of staff on duty was in line with the needs of residents. The staff consisted of a mix of nurses and healthcare assistants, providing the required skill-mix to meet the needs of residents. There was a consistent team of staff in the centre. This meant that the team was familiar to the residents.

Judgment: Compliant

## Regulation 16: Training and staff development

Improvement was required in relation to the training of staff to ensure that they had the required skills to meet the needs of residents.

Inspectors reviewed the staff training records in the centre. These showed that all staff had up-to-date training in safeguarding. Staff also had received training in a human rights-based approach to care. However, staff had not received training in all areas that were required to support residents to meet their needs. Inspectors noted that one resident's speech and language therapy report, devised in December 2023, had recommended that all staff complete training on 'intensive interactions'. On the day of inspection, the person in charge reported that this training had not been completed by any staff member and that there were no plans in place to complete that training. In addition, six of twenty-four staff required refresher training in

supporting residents to manage behaviour that is challenging. Supporting residents with their behaviour was identified as a high-risk for some residents, as noted by inspectors when they reviewed risk assessments. Despite this, on the day of inspection, there was no plan in place for staff to receive refresher training in this area.

Judgment: Not compliant

## Regulation 23: Governance and management

The provider had failed to devise or implement the necessary plans or supports to ensure that residents lived in a centre that was safe and that met their needs. The provider did not had adequate oversight of the service to ensure that residents' safety was protected. The management systems were not adequate to progress known service improvement issues that significantly impacted on the safety of residents and their quality of life.

The inspectors viewed the most recent annual report into the quality and safety of care and support in the centre. This had been completed on 31 October 2024. Inspectors also reviewed the two most recent unannounced provider-led audits that had been completed in the centre. These were completed on 1 October 2024 and 22 April 2024. Neither the annual report nor unannounced audits had adequately identified the significant risks in the centre in relation to the inappropriate living arrangements for two of the residents. This was despite the fact that these issues had been highlighted at the time in resident risk assessments, behaviour support plans and safeguarding plans. There were no actions listed in the annual report or unannounced audits to address these known risks.

The inspectors reviewed the centre's quality improvement plan. This plan listed the actions that needed to be addressed in order to improve the quality of the service as identified through audit and self-assessment. This plan had one recorded action in relation to the inappropriate placement of two residents in the centre. This recorded the goal of relocating the residents. However, the specific steps needed to complete this action had not been identified or recorded on the plan. The target timeline for this action had been changed on numerous occasions indicating that the provider had failed to complete their plans within their own timelines on numerous occasions. Minutes of a staff meeting that was held in the centre on 3 April 2025 indicated that there was a plan for residents to move on 12 April 2025. As outlined above, residents had not yet moved on the day of inspection.

Judgment: Not compliant

## Quality and safety

Significant improvement was required to ensure that all measures to protect the safety of residents were implemented. The provider had not implemented all of the recommendations made in residents' safeguarding plans, behaviour support plans and risk assessments. This significantly impacted on the safety of residents.

The rights of residents were not always promoted in this centre. It was not clear that the residents' health, social and personal care needs had been adequately assessed. Where guidance was provided to staff on how to support residents, this was not always kept up to date. It was not clear that residents were supported to communicate their needs and wishes. The restrictions placed on residents in the centre were not adequately reviewed to ensure that they were the least restrictive options.

## Regulation 10: Communication

The provider did not ensure that residents were supported to communicate their needs and wishes.

The inspectors reviewed the communication profiles for two residents. These had been developed by a staff member familiar with the residents. The communication profiles outlined supports required by the residents when communicating. Both communication profiles referenced recommendations made by a speech and language therapist. However, the corresponding speech and language therapy report had been completed in 2015 when the residents were under the care of paediatric services. Therefore, it was unclear if the recommendations were still relevant, applicable or effective.

Inspectors reviewed a speech and language therapy report that had been developed in 2023 for a third resident. This report made a number of recommendations but not all had been implemented in the centre. For example, the report recommended that objects of reference be used to support the resident with their communication. On the day of inspection, staff reported that these objects were not used with the resident.

Judgment: Not compliant

## Regulation 17: Premises

As outlined in the opening section of the report, the centre did not meet the needs of residents.

The padding needed by one resident was not available to them. Though the padding had been installed in April 2024 in a section of the building that was in keeping with

their needs, the resident had yet to move to that part of the building on the day of inspection. Another resident was living in that area who did not require those supports.

Inspectors noted that there was damage in areas of the building that required repair. There was no definite plan to address this on the day of inspection.

The sensory equipment was damaged and required replacement. The inspectors viewed a proposal in relation to the refurbishment of this room that was signed by a senior manager. The letter was dated November 2024 and outlined the equipment needed for the room. The letter outlined the benefits of this equipment for residents. However, there was no further plan in place to develop the sensory room as outlined in the letter of proposal. In addition, it was noted that relevant suitably qualified professionals had not provided input into the planning of this room to ensure that it met the needs of residents. One resident's speech and language therapy report, recommended a referral to a sensory occupational therapist. The person in charge reported that this had not occurred on the day of inspection.

Judgment: Not compliant

## Regulation 26: Risk management procedures

The provider's systems to identify, manage and review risk was not adequate.

The inspectors reviewed the risk assessments that had been developed for two residents. Neither of these risk assessments had been reviewed in line with the provider's timelines.

Inspectors noted that one resident's risk assessment identified that they were at high risk of severe injury due to their behaviour. The risk assessment outlined the control measures that were in place to reduce the risk. Despite these control measures, the risk remained at a very high level as identified by the provider on their assessment. The risk assessment was developed in September 2024 and had not been reviewed in the intervening period, despite the known risk. It had not been reviewed within the provider's own timeline of 3 months. The identified additional control measures to reduce the risk had not been implemented, namely ensuring that the resident's bedroom and living areas were padded. On the day of inspection, the provider did not have a definite plan to implement these additional control measures. There was no information to staff on the mitigating actions that should be taken in the absence of padding should the resident engage in self-injurious behaviour.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Inspectors were not assured that the health, social and personal needs of residents had been adequately assessed. The designated centre did not meet the needs of each resident.

The centre was not suitable for the purposes of meeting the needs of all residents, as identified in the residents' assessments of need. Given the serious risk to one resident in this regard, the provider was issued with an urgent compliance plan the day after the inspection. This required the provider to outline their plan to ensure that the centre met the needs of residents and that the risk to residents was reduced. The provider returned the plan on 29 April 2025 and outlined that the resident would move to the section of the building that was padded by 10 May 2025.

Inspectors reviewed the assessments of need that had been completed for two residents. It was noted that one resident's assessment was not dated or signed by the person who completed it. Therefore, it was unclear if the information was relevant to the resident.

Inspectors noted that care plans had been developed to guide staff on the supports required by residents to meet their needs. However, these care plans were not kept up to date in line with the provider's timelines. Inspectors noted that care plans were due to be routinely update in March 2025 but, on the day of inspection, this had not occurred. This had been identified by the person in charge through audit of resident files. In addition, the care plans were not updated to reflect new information in relation to the residents' needs. For example, one resident's behaviour support plan was updated in March 2025 by the behaviour support service. However, their corresponding care plan was not updated to reflect this.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

Significant improvement was required in relation to the supports offered to residents in relation to their behaviour and in the review of restrictive practices in the centre.

The inspectors reviewed the behaviour support plans for two residents. They noted that the residents' behaviour support plans were developed by a suitably qualified professional and were regularly reviewed. Staff were knowledgeable of their content. However, not all aspects of the plans were implemented. For example, the multidisciplinary team had highlighted the urgent need for one resident to have padding on the walls of their bedroom and living area to reduce the risk to the resident of a 'dangerous and potentially catastrophic impact on their health and wellbeing'. On the day of inspection, this had not happened and there was no

definite plan for this to occur.

The restrictive practices in the centre were not reviewed to ensure that they were relevant or the least restrictive options. The inspectors reviewed the restrictive practice log in the centre and found that some restrictive practices had been in place for a long time without adequate review to ensure that they were still required. For example, one resident's bathroom and cupboards were locked to restrict their access to toiletries. This was to ensure that these were not consumed by the resident. This practice had been in place for a number of years. However, there were no recorded incidents of the resident engaging in this behaviour in a considerable amount of time and the resident's behaviour support plan did not list this as an identified behaviour of concern. Therefore, it was unclear if this restriction was still relevant or required. The provider did not have a plan to review this restriction or a system to ensure that all restrictions in the centre were regularly reviewed.

Judgment: Not compliant

## Regulation 8: Protection

The provider had not implemented all measures to ensure that residents were protected from abuse.

Inspectors reviewed an open safeguarding plan in the centre. This had been developed in December 2023 and identified that the resident in question required padding to be placed on the walls of their living area. The provider had a target timeline in the safeguarding plan for this action to be completed in February 2024. On the day of inspection, this had not occurred. Correspondence in the resident's file between the behaviour support team and senior management indicated that the padding had been installed in the centre in April 2024. However, the resident had not been relocated to that side of the building and on the day of inspection, another resident was living in that section of the building.

Inspectors reviewed the intimate care plans for two residents. These plans gave details to staff of the supports required by residents. However, these plans were not updated in line with the provider's own timelines. One intimate care plan was dated 14 July 2023 and stated that it should be updated at least annually. This had not happened on the day of inspection.

Judgment: Not compliant

## Regulation 9: Residents' rights

Significant improvement was required in relation to the promotion of the rights of

residents in the centre.

Inspectors noted that one resident was living in a section of the building that was fitted with padding in their bedroom and living rooms. This padding was not required by the resident. It had been placed in their bedroom a year previously. The person in charge reported that there was no documentation to demonstrate that the resident had been consulted about this at the time the padding was installed.

Inspectors reviewed the minutes from the residents' meetings that were held in the centre in January 2025. They noted that there were no records of meetings for two weeks in January or an explanation as to why these meetings had not occurred.

A definite transition plan to support two residents in relation to their transfer within the centre had not been developed on the day of inspection. This meant that a plan to offer choices to resident in relation to their living environments had not been developed or initiated. The necessary supports from relevant professionals in relation to this transfer had not been identified or put in place.

The letter from senior management in relation to the development of a sensory room in the centre outlined a complaint from residents. It stated that residents had highlighted in resident meetings that they would like to have use of a sensory room. Residents had noted that the sensory room equipment had been damaged and broken and not replaced. On the day of inspection, though the issue had been highlighted by management, there was no definite plan to address this complaint.

Judgment: Not 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 | Not compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Not compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Ballytrim House OSV-0002523

## Inspection ID: MON-0046605

## Date of inspection: 24/04/2025

**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:

• The Person in Charge has reviewed the Centre's training matrix. All staff have been provided with their updated individual training needs analysis and have been advised on the date this should be completed by which will be strictly monitored by the Person in Charge. Date completed: 12.05.25.

• The person in charge had scheduled refresher training for six staff in the management of behavior of concern. Four staff have completed training on the 19.05.25 – Two staff unable to attend the studio 3 refresher training on 19.05.25 have been rescheduled to attend this training on the 19.06.25: Date for completion 19.06.25

• The Person in charge has scheduled training for three key staff for intensive training to be carried out the speech and language therapist to support two residents who require additional supports with their communication as recommended by speech and language therapist: Date for completion: 24.06.25.

• The Person in Charge has liaised with the speech and language therapist to provide training in communication to all staff in Centre. This will be delivered through an onsite workshop. Date for completion: 24.06.25

• The Person in Charge has liaised with Clinical Psychologist who will provide a human rights workshop for staff. Date for completion: 17.06.25.

• The Person in Charge has arranged for all Nurses to attend a Care planning workshop. Date for completion 03.06.25.

• The Person in Charge will continue to monitor the training matrix on a monthly basis and schedule training as required – Date completed 12.05.25.

| | |
|---|---|
| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The Person in Charge assisted by the Assistant Director of Nursing have reviewed the Centres Quality Improvement Plan. Specific steps for relocating two of the residents within the Centre have been included to Quality Improvement plan which was completed on the 28.04.25

• The Provider Representative completed an unannounced visit and walk around of the centre on the 29.04.25. A number of actions were identified from provider Inspection visit have been included on the centre's Quality Improvement Plan with identified timeframes for monitoring until closed out. Date Completed: 13.05.25.

• The Person in Charge will review the Centre's Quality Improvement Plan weekly in liaison with the Assistant Director of Nursing, Director of Nursing and Service Manager on a weekly monitoring basis. The QIP will be further monitored through the General Managers Office by the Regional Director of Nursing. Additional monitoring commenced on the 14.05.25 and will be ongoing.

• The Person in Charge has scheduled all staff for outstanding training with emphasis on training in Communication, Studio 3 refresher training and Care Planning– Dates for completion: 30.06.25.

• Senior Management will complete unannounced "Walk Arounds" of Centre on a monthly basis at a minimum. This commenced on the 07.05.25 and will be ongoing.

• The Person in charge has liaised with the Maintenance Manager and Infection Control staff and scheduled a date to complete a walk around of premises to identify any further upgrade works necessary for premises. Date completed 27.05.25

• The maintenance manager and Infection prevention control will provide a report on the identified works required within the centre. Date for completion: 30.06.25

• Senior management have completed an audit on all resident care plans. Date Completed:14.05.25.

• All actions identified from the audits of the care plans have been provided to and discussed with the named nurses with a timeframe to complete all outstanding actions. Date for completion: 30.05.25

• The Provider has discussed with all provider delegates the importance and requirement of ensuring that all safeguarding issues and risks within a centre are clearly identified in the unannounced 6 monthly and annual review reports. Date completed 22.05.25. In addition to this instruction on this will be provided to all provider delegates by the Regional Director of Nursing on the 12.06.25

• The person in charge in liaison with residents named nurses have had a discussion with the two identified residents in relation to their internal transition and this was supported by the Multi-Disciplinary team. Easy read documentation was utilised as part of this discussion which has been provided by the Speech & language therapist. Date Completed: 09.05.25

• As planned and agreed with the multi-disciplinary team one resident has relocated to the identified annex within the centre (with approved padding) and a second resident has relocated to the opposite annex area. Date of completion 10.05.25

| | |
|---|---|
| Regulation 10: Communication | Not Compliant |

Outline how you are going to come into compliance with Regulation 10: Communication:
• The Person in charge has scheduled training for three key staff for intensive training carried out by speech and language therapist to support two residents who require additional supports with their communication as recommended by speech and language therapist: Date for completion: 24.06.25.
• The Person in Charge has liaised with the speech and language therapist to provide training in communication to all staff in Centre. This will be delivered through an onsite workshop. Date for completion: 24.06.25
• The Person in Charge has requested the Speech and Language therapist to review previous recommendations made to ensure that they reflective of the resident's current status in relation to "objects of reference". Date for completion: 20.06.25.
• The Person in Charge has liaised with the Speech and Language therapist to complete a further review of two residents who were previously reviewed and received recommendations while under the care of paediatric services. Date for Completion: 30.06.25.

| | |
|---|---|
| Regulation 17: Premises | Not Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Person in Charge has implemented a definitive plan for all outstanding repairs to ensure that two residents relocate from their current living areas. One resident to padded area as prescribed and the other to their identified area. Date Completed 25.04.25
• The Person in charge will continue to liaise with maintenance to ensure that all works that remain outstanding in relation to wall tiling in all ensuite bathrooms to extend the splash backs to reduce damage to the walls. Cladding placed on 5 ensuite walls to date and there remains 4 more to be completed. Date for completion 30.06.25
• Staff have supported one of the identified residents to choose colours, new curtains and bedding for their new living area as part of their transition plan. Date Completed 09.05.25
• Staff have supported the other identified residents to choose colours, new curtains and bedding for their new living area as part of their transition plan. Date Completed: 09.05.25
• Senior staff nurse discussed transition plan with one of the identified resident's next of Kin on the 07/05/2024 and19/09/24. The person in charge has also had a discussion with the next of kin on the 25.04.25
• As planned and agreed with the multi-disciplinary team one residents has relocated to the identified annex within the centre (with approved padding) and another resident has relocated to the opposite annex area. Date Completed 09.05.25

• The Person in charge has liaised with the Maintenance Manager and Infection Control staff and scheduled a date to complete a walk around of premises to identify any further upgrade works necessary for premises Date for completion 31.05.25
• The Person in Charge has liaised with a private Sensory OT to carry out an assessment as recommended by Speech and Language therapist and to apply for funding for same. Date for Completion: 30.06.25
• The Person in Charge has liaised with the company who is completing the upgrading of the Sensory room. This has been completed however there is some damage to the padding and new equipment has been ordered to replace damaged equipment and this will be installed by 13.06.25. Date for Completion: 13.06.25
• All maintenance work has been completed for areas where both of the identified residents have transitioned to. Date completed:10.05.25

| | |
|---|---|
| Regulation 26: Risk management procedures | Not Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in charge and the Assistant Director of Nursing in liaison with the Director of Nursing have reviewed the risk register and all risks within the centre with an emphasis on those relating to the two identified residents transition. Date Completed: 12.05.25
• The Person in Charge has discussed with all nurses their requirements to ensure that all nursing care plans are reviewed and evaluated within the required 3 month timeframe with particular emphasis on the evaluations of all risk assessment. Date for Completion 31.05.25.
• The Assistant director of nursing and Director of Nursing have completed an audit of all nursing care plans within the centre which included risk assessments for each resident. Date Completed 14.05.25. –
• Following the audit of care plans by the Director of Nursing and the Assistant Director of Nursing all nurses have been provided with a copy of the audit and the action plan for all actions to be completed. Date for completed 31.05.25
• The Person in Charge in liaison with residents named nurses have had a discussion with the two identified residents in relation to their internal transition and this was supported by the Multi-Disciplinary team. Easy read documentation was utilised as part of this discussion which has been provided by the Speech & language therapist. Date Completed: 09.05.25
• As planned and agreed with the multi-disciplinary team one resident has relocated to the identified annex within the centre (with approved padding) and the other resident has relocated to the opposite annex area. Date of completion 10.05.25
• Meeting held on 08.05.25 with the Multi-Disciplinary team which includes Senior Clinical Psychologist, Clinical Nurse Specialist in Positive Behaviour Support, Speech and Language Therapist and Clinical Nurse managers where all of the environmental restrictive practices within the centre have been reviewed. A schedule of dates for

| |
|---|
| quarterly meetings for review has been developed. |

| | |
|---|---|
| Regulation 5: Individual assessment and personal plan | Not Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• The person in charge in liaison with residents named nurses have had a discussion with both identified residents in relation to their internal transition and this was supported by the Multi-Disciplinary team. Easy read documentation was utilised as part of this discussion which has been provided by the Speech & language therapist. Date Completed: 09.05.25

• Transition plans for both identified residents have been developed and reviewed with the support of the Multi-Disciplinary team. Date Completed: 09.05.25

• Both identified residents Positive Behaviour Support Plans have been updated by the senior clinical psychologist to ensure that all the required information is contained within each plan and that it is up to date. Date completed: 29.04.25

• Staff have supported one the identified residents to choose colours, new curtains and bedding for their new living area as part of their transition plan. Date Completed 09.05.25. Staff have supported the other identified resident to choose colours, new curtains and bedding for their new living area as part of their transition plan. Date Completed: 09.05.25

• Senior staff nurse discussed transition plan with one of the identified resident's next of Kin on the 07.05.24 and 19.09.24 The person in charge has also had a discussion with the next of kin on the 25.04.25

• As planned and agreed with the multi-disciplinary team one of the identified residents has relocated to their identified annex within the centre (with approved padding) and the other identified resident has relocated to the opposite annex area. Date of completion 10.05.25

• The Person in Charge has met with both identified residents Named nurse to discuss deficits within the nursing care plan to include; review/evaluation, updating of risk assessments, nursing interventions and Person-centred planning goals. All deficits identified have been rectified and these have been reviewed by the Assistant Director of Nursing and the Person in Charge. Date completed: 25.04.25

• The Director of Nursing, Assistant Director of Nursing and the Person in Charge have completed the auditing of care plans for all residents in centre. Actions identified from audit have been communicated to nurses for completion of actions with date identified for completion. Date completed: 14.05.25

• The Assistant Director of Nursing in liaison with the Director of Nursing have reviewed the risk register and all the risks within the centre with an emphasis on those relating to both identified residents move. Date Completed: 12.05.25

• Residents in the centre will continue to be supported by consistent and regular staff as per their assessed needs.

• All incidents of safeguarding will continue to be reported to the safeguarding and

protection team as per the safeguarding of vulnerable adults at risk of abuse policy and also to the regulator within the required timeframes. ·
• One of the identified residents is reviewed at the Donegal disability safeguarding meetings which are held quarterly. Last meeting was 26.05.25 and ongoing ·
• Meeting held on 08.05.25 with the Multi-Disciplinary team which includes Senior Clinical Psychologist, Clinical Nurse Specialist in Positive Behaviour Support, Speech and Language Therapist and Clinical Nurse managers where all of the environmental restrictive practices within the centre have been reviewed. A schedule of dates for quarterly meetings for review has been developed. ·
• All maintenance works identified to date within the centre have been completed on the 09.05.25 which include;
· Wet room panelling installed.
· Discoloured plugs replaced.
· Floor covering in one of the identified residents new living quarters replaced as per person in charge self-assessment.
· Storeroom decanted in padded area to another area to provide an additional room
· Protective padding replaced over radiators in Padded area and over one wardrobe door
· Magnetic lock placed on one identified door and restrictive log updated to reflect this.
· All required painting within the centre completed.

• All actions from compliance plan have been included on the centres Quality Improvement plan for monitoring weekly by Director of Nursing and Service Manager. Date completed: 28.04.25.
• The centres QIP has also been included for weekly monitoring through the General Manager's Office by the Regional Director of Nursing. Date completed 14.05.25 and ongoing
• Ongoing de-congregation meetings have occurred to progress the de-congregation of the designated centre. Approval for additional staff to support de-congregation received on the 17.04.25.
• Date for de-congregation has been extended to 01.07.25 to facilitate the appointment of relevant staff grades.

| | |
|---|---|
| Regulation 7: Positive behavioural support | Not Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Both identified residents Positive Behaviour Support Plans have been updated by the senior clinical psychologist to ensure that all the required information is contained within each plan and that it is up to date. Date completed: 29.04.25·
• The Person in Charge has liaised with Clinical Psychologist and Clinical Nurse Specialist in behaviour management and Speech and Language therapist to review of all restrictive practice within the Centre. Date Completed: 28.04.25.
• The Person in Charge has implemented a definitive plan for all outstanding repairs to

ensure that two residents move from their current living areas. Date Completed 25.04.25

| Regulation 8: Protection | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Person in Charge has developed a definite plan as outlined in regulation 5 and 17 of Compliance plan. This is for one of the identified residents moving to padded area as prescribed as part of safeguarding plan and for the other identified residents relocating to their identified area. Date Completed 10.05.25.
• The Person in Charge in liaison with the named nurse and Multi-disciplinary team has ensured that two of the identified residents care plan, intimate care plan, risk assessment, behavioural support plan and safeguarding plans have been updated to reflect completion of their move within the centre. Date completed 16.05.25.
• The Person in Charge has reviewed all overarching safeguarding plans within the centre to ensure that these are reflective of the current status for all residents and that these are implemented. Date Completed: 12.05.25
• The person in charge in liaison with residents named nurses have had a discussion with the two identified residents in relation to their internal transition and this was supported by the Multi-Disciplinary team. Easy read documentation was utilised as part of this discussion which has been provided by the Speech & language therapist. Date Completed: 09.05.25
• As planned and agreed with the multi-disciplinary team one resident has relocated to the identified annex within the centre (with approved padding) and another resident has relocated to the opposite annex area. Date of completion 10.05.25
• One of the identified residents is reviewed at the Donegal disability safeguarding meetings which are held quarterly. Last meeting 26.05.25 and ongoing
• The person in charge will continue to attend quarterly safeguarding meetings with the safeguarding and protection team in attendance.

| Regulation 9: Residents' rights | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Person in Charge has developed a definite plan as outlined in regulation 5 and 17 of Compliance plan. This is for one resident moving to padded area as prescribed as part of safeguarding plan and for another resident relocating to their identified area. This included transition plan for both resident documenting consultation with them. Date Completed 10.05.25.
• The Person in Charge has reviewed the minutes of residents meeting held within the Centre. They have developed a schedule for residents meetings which includes the

resident who resides in the annex. The Person in Charge has communicated this to all nurses to ensure meetings are held each weekend. Date Completed 08.05.25.
• The Person in Charge and the Assistant Director of Nursing will review the minutes of the residents meeting weekly. Date completed 21.05.25
• The Person in charge will attend residents meeting bi monthly Date for completion 31.05.25 and ongoing
• The Person In Charge has liaised with Clinical Psychologist and Clinical Nurse Specialist in behaviour management and Speech and Language therapist to review of all restrictive practice within the Centre including the padding for one resident who did not require it but was residing in that area. Date Completed: 28.04.25.
• The Person in Charge has liaised with the company who is completing the upgrading of the Sensory room. This has been completed however there is some damage to the padding and new equipment has been ordered to replace damaged equipment and this will be installed by 13.06.25. Date for Completion: 13.06.25
• All staff have completed training in Human rights and the Person in Charge has liaised with Clinical Psychologist who will provide a human rights workshop for staff. Date for completion: 17.06.25.

## 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. | Not Compliant | Orange | 30/06/2025 |
| Regulation 10(2) | The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan. | Not Compliant | Orange | 30/06/2025 |
| 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 | Not Compliant | Orange | 24/06/2025 |

| | | | | |
|---|---|---|---|---|
| | development programme. | | | |
| Regulation 17(1)(a) | The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents. | Not Compliant | Orange | 30/06/2025 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Not Compliant | Orange | 30/06/2025 |
| 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. | Not Compliant | Orange | 30/06/2025 |
| 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 | Not Compliant | Orange | 31/05/2025 |

| | | | | |
|---|---|---|---|---|
| | 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. | Not Compliant | Orange | 01/07/2025 |
| Regulation 05(2) | The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1). | Not Compliant | Orange | 01/07/2025 |
| Regulation 05(3) | The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1). | Not Compliant | Red | 01/07/2025 |
| Regulation 07(5)(c) | The person in charge shall ensure that, where | Not Compliant | Orange | 29/04/2025 |

| | | | | |
|---|---|---|---|---|
| | a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used. | | | |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 16/05/2025 |
| Regulation 09(2)(a) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support. | Not Compliant | Orange | 17/06/2025 |
| Regulation 09(2)(e) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre. | Not Compliant | Orange | 17/06/2025 |
| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is respected in | Not Compliant | Orange | 17/06/2025 |

| | | | | |
|---|---|---|---|---|
| | relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | | | |