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:	St Anne's - Naomh Áine's
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Announced
Date of inspection:	13 July 2022
Centre ID:	OSV-0007235
Fieldwork ID:	MON-0028281

About the designated centre

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

Naomh Aine's can provide full time residential care for four male and female residents who are over the age of 18 years and who have a diagnosis of moderate intellectual disability. The service can also support varying care needs which include support with mental ill health, dietary needs, medical needs, visual impairment, behaviours of concern, and care associated with ageing. The staff team consist of nurses and health care assistants, who are available at all times when residents are present in the centre. The centre is a detached house in a rural, coastal area, and there is transport provided for residents to access the amenities in their locality.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 13 July 2022	09:15hrs to 16:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This centre is run by the Health Service Executive (HSE) in Community Healthcare Organisation Area 1 (CHO1). Due to concerns about the management of safeguarding matters and overall governance and oversight of HSE centres in Co. Donegal, the Chief Inspector undertook a review of all HSE centres in Donegal. This included a targeted inspection programme which took place over two weeks in January 2022 and focused on Regulation 7 (Positive behaviour support), Regulation 8 (Protection) and Regulation 23 (Governance and management). The overview report of this review has been published on the HIQA website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspector have now commenced a programme of inspections to verify whether these actions have been implemented, as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Donegal.

At the time of the inspection, some of the actions outlined above had commenced and others were completed. These will be discussed in the other sections of the report.

St Anne's – Naomh Áine's was located in a scenic coastal location in a rural area. It was within driving distance of a small town where there were shops, hairdressers and other community amenities. The property provided was a spacious two story house, which was bright, homely and in a good state of repair. The inspector saw that there was a shared kitchen and dining room, with a sitting room adjacent to this. The doors of the sitting area opened out on to an accessible patio where outdoor furniture was provided, planters were displayed and the bins were stored in a manner that was neat and tidy. There was a shed in this area which was used for the storage of personal protective equipment (PPE). The mops and buckets used for cleaning were in the downstairs bathroom and the system in place for their storage required review. Each resident had their own bedroom. The female residents had a shared accessible bathroom, while the male residents had en-suites provided. This arrangement was working well. One resident invited the inspector into their bedroom. It was well presented and decorated nicely. There was an arrangement of person possessions which the resident enjoyed using and organising. The inspector could see that the resident enjoyed spending time in their room and was noticed sitting there later in the day. They were also observed singing quietly while sorting and folding laundry. A second resident rose later in the morning. They were enjoying a cup of tea at the table while looking at magazines. Their hair was freshly washed and styled in rollers by the staff on duty.

The person in charge told the inspector that some residents went to day services while others preferred to remain at home. For example, one resident had left early that morning. A second was departing as the inspector arrived. This resident had

requested a specific driver to support them and this request was provided for in accordance with the residents request. The third resident had reduced attendance at the day service. The staff said that they enjoyed the day service but as they were advancing in age, there were days when they preferred to stay at home. The fourth resident had a visit from their family on the day of inspection which they very much enjoyed. The person in charge told the inspector that they did not attend day services at that time. An alternative location was identified and a taster session was arranged to see how they would get on. This would involve going for a visit and for a cup of tea.

Most residents had contact with their family and their friends. This was facilitated through telephone calls, visits to the designated centre and visits home. Some residents had contact with their friends and an example of this will be expanded on later in this report. All residents were actively involved in their communities through visits to the day centre, to the shops, to the hairdresser and trips out for lunch. There was a range of scenic beaches close by and residents were observed planning a walk there later in the evening. Activities were planned through residents' meeting which took place regularly. As well as planning outings, residents discussed menu planning, shopping lists, health and safety and managing their money. Minutes were available in easy-to-read version for the residents use.

There was one staff member on duty on the morning of inspection as well as the person in charge. The staff member was very familiar with their role and were observed to support residents in a caring and respectful manner. There was a warm and friendly atmosphere in the house. Interactions observed between residents and staff were cheerful and engaging. The inspector had an opportunity to speak with two staff members as part of this inspection. Both reported that they enjoyed their work in St Anne's – Naomh Áine's and that it was a pleasant working environment. Staff meetings were taking place regularly and both staff members said that they felt supported in their work. The inspector also had an opportunity to meet with the family members of two residents and spoke with another resident's family member by telephone. All those spoken with said that they were happy with the care and support provided and that their relatives appeared happy and safe in their home. One person said that their relative enjoyed smaller groups and that the family did not have to worry anymore. However, another had some concern in relation to resident's assessed healthcare needs. This concern was under the assessment and support of the general practitioner (GP) and members of the multi-disciplinary team. This showed that through attention was given to matters raised and that open and ongoing communication between the family members and the person in charge was encouraged and facilitated.

In general, the inspector found that the service provided a quality, safe and person-centred service to residents. The residents living there appeared happy in their home environment and had meaningful activities planned for their day.

The following sections of this report outline the governance and management arrangements and how this impacts on the quality and safety of care provided to residents.

Capacity and capability

As outlined above, this inspection was carried out to monitor compliance with the regulations and to review the provider's actions from the targeted inspections completed in January 2022. The inspector found that there was a good organisational structure in place with clear lines of accountability and that there were arrangements in place for monitoring and auditing at the centre. However, improvements were required in a number of areas including the written policies and procedures used and the provision of the staff training and staff development required.

The provider had prepared a statement of purpose which was recently reviewed in preparation for a renewal of registration application. It contained the information required under schedule 1 of the regulation an easy-to-read version was available for residents use.

The person in charge worked full-time and was had the knowledge, skills and experience necessary in order to lead the service. They had responsibility for one other designated centre in the county. They informed the inspector about actions that had been implemented as part of the provider's action plan from the overview report. In relation to governance and management, 11 actions were completed. For example, at centre level, staff governance meetings were taking place every two months and the person in charge was meeting with their line manager on a monthly basis. A schedule was in place to ensure that these meetings were planned in advance and therefore sustained. At network level, governance meetings had commenced in relation to quality, safety and service improvement (QSSIM) and the health and safety representative had training provided. The safeguarding review meeting was included as part the QSSIM agenda. At county level, the person in charge meetings had commenced and there was evidence provided that these were taking place every two weeks. These meetings provided opportunities for discussion on current issues and/or concerns, and included guest speaker presentations. The person in charge also attended the policy, procedure, protocol and guidelines development group (PPPG) during which polices, procedures and guidelines were reviewed and updated. The human rights committee meetings had commenced and although the person in charge was not an attendee, the information was cascaded outwards to the designated centres. There were other meetings occurring that did not include the contribution of the person in charge, however, they were aware of these. For example; the meetings held to support the senior management team, the county level disability governance meetings and the governance meetings for quality safety and service improvement meetings.

A range of audits were in use in St Anne's - Naomh Áine's and a review of these had commenced at CHO1 level. The person in charge told the inspector that these were

reviewed at the person in charge meetings. Mandatory audits were used and in addition, there were two service specific audits in use in relation to auditing the management of medications and auditing the accidents and incidents that may occur in the service. This was to ensure that information gathered as part of the national incident management system was adequately identified and an action plan put in place if required.

The impact of these changes was discussed with the person in charge who told the inspector that the increased opportunities for contact through formal meetings was very helpful and supportive. This was because there were opportunities to meet with peers, for shared learning, to reduce the feelings of isolation in the role and to increase the sense of team involvement.

The annual review of care and support was completed in December 2021 and included contributions from residents and their families. The six monthly provider-led audit was completed in March this year when an unannounced visit took place. Actions highlighted through both of these governance processes were highlighted in the designated centres quality improvement plan. Staff spoken with told the inspector that they enjoyed their work, that they felt supported and that they would feel comfortable raising a concern if required.

A review of the policies and procedures available for staff was completed. The inspector found that although most were subject to regular review, three of the policies on file were out of date. These included the policy on the provision of behavioural support, the policy on staff training and development and the policy on recruitment, selection and garda vetting of staff. The person in charge told the inspector that they were attending the policy, procedure, protocol and guidance (PPPG) meetings and that the requirement for updating could be addressed through this pathway. This showed that the systems in place for escalation of concerns were working well.

The staffing arrangements in the centre were reviewed as part of the inspection. The skill-mix detailed in the statement of purpose (SOP) included nursing staff and healthcare assistants. There was a planned and actual rota in place which showed that there were a sufficient number of staff on duty to support residents. There was a minimum of two staff required during the daytime. The night-time cover arrangement comprised of a sleep over and a waking night staff and there was evidence that this was provided. There was an on-call arrangement in place and staff spoken with told the inspector that this worked well, for example, if they required nursing support at the weekends that they were aware of who to call. Furthermore, there was a consistent group of agency staff who were available to provide support if required. This showed that residents received continuity of care and support.

The provider had a list of mandatory training that staff were required to complete as part of their continuous professional development. The provider had introduced a new training needs analysis and training matrix for use in the service. This action was identified by the provider and submitted as part of their recent compliance plan. The inspector reviewed a sample of the training modules provided and found that

the majority were up to date. However, there were gaps in the completion of the refresher training programmes on positive behaviour support. This module was essential to the assessed support needs of the residents in the service and the organisation of this training required prioritisation. Furthermore, the inspector found that the systems in place to provide staff with support and supervision were not up to date. The person in charge was aware of this and had a plan in place to address the gap identified.

Overall, the inspector found that the staff recruited and trained to work in this centre, along with good governance arrangements ensured that in the main, a safe and effective service was provided in this centre.

Regulation 14: Persons in charge

The person in charge worked full-time and was had the knowledge, skills and experience necessary in order to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the number, qualifications and skill mix of staff employed was appropriate to the number and assessed needs of the residents and the size and statement of purpose of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training including refresher training as part of a continuous professional development programme and a training matrix was in place. However, the inspector found that the following required review:

- the systems in place to provider refresher training in positive behaviour support
- the systems in place to provide staff with support through a programme of formal supervision.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangement at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO 1.

On the day of inspection the person in charge told the inspector that 11 actions in relation to governance and management had been implemented as part of the provider's action plan from the overview report.

- At centre level, staff governance meetings were taking place every two months and the person in charge was meeting with their line manager on a monthly basis.
- At network level, governance meetings had commenced in relation to quality, safety and service improvement (QSSIM). The safeguarding review meeting was included as part the QSSIM agenda. The person in charge reported that this provided opportunities for shared learning, advice and support.
- At county level, the person in charge meetings had commenced and there was evidence provided that these were taking place every two weeks. These meetings provided opportunities for discussion on current issues and/or concerns and included guest speaker presentations. The person in charge also attended the policy, procedure, protocol and guidelines development group (PPPG) during which polices, procedures and guidelines were reviewed and updated.
- A range of audits were in use in this designated centre and a review of these had commenced at CHO1 level. Mandatory audits were used and in addition, there were two service specific audits in use in relation to medication management and auditing the accidents and incidents that may occur in the service.

The annual review of care and support was completed in December 2021 and included contributions from residents and their families. The six monthly provider-led audit was completed in March this year when an unannounced visit took place. Actions highlighted through both of these governance processes were highlighted in the designated centres quality improvement plan.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which was recently reviewed in preparation for a renewal of registration application. It contained the information required under schedule 1 of the regulation an easy-to-read version was available for residents use.

Judgment: Compliant

Regulation 4: Written policies and procedures

A review of the policies and procedures available for staff was completed. The inspector found that although most were subject to regular review, three were out of date. These included:

- the policy on the provision of behavioural support
- the policy on recruitment, selection and garda vetting of staff
- the policy on staff training and development

Judgment: Substantially compliant

Quality and safety

The inspector found that residents living in St Anne's – Naomh Áine's were provided with a person-centred service which strived to ensure that residents' wellbeing and personal needs were met. However, improvements were required to ensure that policies, procedures and training was up-to-date, storage of cleaning equipment was reviewed and that matters in relation to positive behaviour support, safeguarding were pursued in accordance with the providers compliance plan.

The inspector reviewed a sample of residents' care and support plans. It found that annual review meetings took place with the maximum participation of residents and their representatives, where relevant. Residents were found to have up-to-date assessments completed of their health, personal and social care needs and these were available in easy-to-read format. Each resident had a keyworker allocated to them and they supported the residents to set individual goals and to work towards achieving them. For example, one resident like to walking and enjoyed visits to the beach. Their goal involved assisting with a community beach cleaning day and this was achieved. Another resident wished to meet with their friend. A trip to a spa resort was planned and the resident went there with their friend. The resident enjoyed showing the inspector a picture book that documented their day out

together.

The provider had ensured that appropriate health and wellbeing supports were facilitated for each resident at this designated centre. Residents had access to a general practitioner and consent was sought in relation to their care and support for example; vaccination consent. A review of the documentation showed that residents had access to a variety of allied healthcare professionals in accordance with their assessed needs. There was evidence of ongoing support by the physiotherapist, speech and language therapist and dietetics. For example, one resident required support with weight management and assessment and intervention in this regard was ongoing. On another occasion support from a respiratory consultant was required and this was followed up on promptly. Furthermore, residents had access to national screening services if they were eligible for such supports, for example; breast and bowel check.

Residents that required support with behaviours of concern had positive behaviour guidelines and support plans in place. The inspector discussed recent notifications submitted with the person in charge and reviewed the documentation to support behaviours of concern that was held on site. It was evident that staff were very familiar with the supports required by individual residents and that they monitored residents' wellbeing and presentation carefully. Furthermore, they were aware of behavioural triggers and of how to divert and de-escalate a situation if required. Recently, an escalated risk was identified. The person in charge arranged a meeting with a psychologist in attendance during which the positive behaviour support plan was updated. The person in charge confirmed that in line with the provider's recent commitments; an additional speech and language therapy post was in place and a referral for support was made. Restrictive practices were in use in this centre and a site specific restrictive practice protocol was in place .Furthermore, a restrictive practice log was in use and this was reviewed quarterly. This was another action put in place by the provider as part of their compliance plan submitted. There were five further actions in relation to positive behaviour support and the inspector found that five of these were fully implemented and one was implemented partially. This related to the fact that the director of nursing/area co-ordinator was to review the induction pack in consultation with the person in charge.

Safeguarding practices used in this centre were reviewed and the inspector found that residents were adequately safeguarded against potential abuse. The provider had a safeguarding policy in place and this was up-to-date and reviewed regularly. Where a concern arose, this was followed up on promptly by the person in charge and in line with safeguarding procedures. Safeguarding plans were developed as required. Safeguarding was a standing agenda item on the staff governance meetings which were held in the centre. All staff had training in safeguarding and protection of vulnerable adults and access to designated officers was provided. As part of the provider's compliance plan, a safeguarding tracker was to be introduced for each network area by the end of March 2022. At the time of this inspection, the safeguarding tracking log was in use and the additional weekly cross referencing of incidents had commenced. The person in charge told the inspector that the information gathered was shared and actioned through the QQISM forum. Training on preliminary screening of safeguarding concerns was provided and reported to be

very helpful. Of the 13 actions proposed by the provider, there was evidence that 12 of these actions were completed and one was in progress. This referred to the development of a policy on the safe use of wifi which was not completed by the date proposed by the provider.

The provider ensured that there were systems in place for the prevention and control of infection. This included staff training, posters on display around the house about prevent infection transmission, use of personal protective equipment (PPE) and availability of hand sanitisers. In addition, there were systems in place for the prevention and management of the risks associated with COVID-19; including up-to-date outbreak management plans, risk assessments and ongoing discussion with residents about the risks of COVID-19. However, the arrangements in place for the storage of environmental cleaning equipment required review.

Regulation 27: Protection against infection

The provider ensured that there were systems in place for the prevention and control of infection including the risk associated with COVID-19. These included up-to-date outbreak management plans, risk assessments and ongoing discussion with residents about the risks of COVID-19. However, the arrangements in place for the storage of environmental cleaning equipment required attention as follows:

- mop heads were stored in bucket in a small toilet. This arrangement required review.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' had up-to-date annual review meetings which took place with the maximum participation of residents and their representatives, where relevant. Residents were found to have up-to-date assessments completed of their health, personal and social care needs and these were available in easy-to-read format. Individual goals were set and there was evidence that these were regularly reviewed and updated accordingly.

Judgment: Compliant

Regulation 6: Health care

Residents' had access to a general practitioner and to a variety of allied healthcare professionals in accordance with their assessed needs. Multidisciplinary meetings took place if required, access to consultant led services was facilitated and residents attended national screening services if they were eligible for such supports.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements in relation to positive behavioural support. One action related to multi-disciplinary supports, three actions related to staff training and in ensuring staff had adequate knowledge about behaviour support plans and three actions related to the induction of new staff.

The inspector found that residents that required support with behaviours of concern had positive behaviour support plans in place. These were reviewed and updated regularly. Restrictive practices were in use in this centre and a site specific restrictive practice protocol was in place. Furthermore, a restrictive practice log was in use and this was reviewed quarterly. This was an action put in place by the provider as part of their compliance plan submitted and referred to above. There were six further actions in relation to positive behaviour support and the inspector found that five of these were fully implemented and one was implemented partially. This related to the following:

- the director of nursing/area co-ordinator was to review the induction pack in consultation with the person in charge.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving governance arrangements in relation to safeguarding and protection.

Safeguarding practices used in this centre were reviewed and the inspector found that residents were adequately safeguarded against potential abuse. The provider had a safeguarding policy in place and this was up-to-date and reviewed regularly. Where a concern arose, this was followed up on promptly by the person in charge and in line with safeguarding procedures. Safeguarding plans were developed as

required. Safeguarding was a standing agenda item on the staff governance meetings which were held in the centre. All staff had training in safeguarding and protection of vulnerable adults and access to designated officers was provided. As part of the provider's compliance plan, a safeguarding tracker was to be introduced for each network area by the end of March 2022. At the time of this inspection, the safeguarding tracking log was in use and the additional weekly cross referencing of incidents had commenced. Training on preliminary screening of safeguarding concerns was provided. Of the 12 actions proposed by the provider, there was evidence that 12 of these actions were completed. The following action was not completed by the date proposed by the provider:

- the development of a policy on the safe use of wifi which was not completed by the date proposed by the provider.

Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for St Anne's - Naomh Áine's OSV-0007235

Inspection ID: MON-0028281

Date of inspection: 13/07/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with regulation 16 Training & Staff Development the following actions has been taken • The PIC arranged the following training for Positive Behavioural Support Training for six staff Completion date: 26/07/2022 & 27/07/2022 • The PIC arranged staff Performance achievement meetings with thirteen staff Completion date: 14/07/2022 – 08/08/2022.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: To ensure compliance with regulation 4 Written Policies and procedures the following actions has been taken • Practice Development Coordinator in conjunction with the IDS policy group have updated the following policies Positive Behavioural Support Policy & Procedure and Staff training and development Policy & Procedure. Completion date: 21/07/2022 • The updated policies have been circulated to the PIC. Completion: 31/07/2022 • The PIC has developed a plan to ensure all staff read and sign all updated policies Completion date: 15/09/2022	

• The PIC is currently linking with HR department regarding updating of the Policy on Recruitment Selection and Garda Vetting of staff. Completion date: 30/09/2022

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
To ensure Compliance with regulation 27 Protection against infection the following action has been taken

• The PIC has put arrangements in place for the appropriate storage of environmental cleaning equipment ie. Mop heads. Completion Date: 29/09/2022

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To ensure compliance with regulation 7 Positive Behavioral Support the following action has been taken

• The PIC in consultation with the A/DON will ensure that the induction pack is reviewed and available in the centre. Completion Date: 27/07/2022

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance with Regulation 8 Protection the following action will be taken

• The service is currently developing a Donegal policy on the provision of safe Wifi usage in conjunction with the Digital Health Lead, Health and Social Care Professionals and in consultation with other care group services. Completion date: 31/12/2022

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	27/07/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	08/08/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of	Substantially Compliant	Yellow	29/07/2022

	healthcare associated infections published by the Authority.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/09/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	27/07/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022