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:	Fernhill Respite House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Short Notice Announced
Date of inspection:	03 November 2022
Centre ID:	OSV-0003338
Fieldwork ID:	MON-0036898

About the designated centre

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

The provider describes the service offered as a four day and three night planned holiday respite break for male and female adults aged 18-65 years with a physical and/or sensory disability in a community setting. Fernhill Respite House is a bungalow situated in a residential housing development, in close proximity to the local town centre. Each resident has their own bedroom, and share the kitchen, main bathroom and sitting room facilities. Respite breaks are offered to over 30 service users, and up to three people can avail of a break at any one time. There are usually two staff on duty, this includes a sleepover arrangements. Staffing provision can be adjusted according to the needs of residents availing of respite.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 3 November 2022	10:00hrs to 16:00hrs	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 concerns and overall governance and oversight of HSE centres in Co. Donegal, the Chief Inspector undertook a review of all HSE centres in that county, including a targeted inspection programme which took place over two weeks in January 2022 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection) and regulation 23 (Governance and management). The overview report of this review has been published on the HIQA website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors are now completing 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 in Fernhill, the provider had implemented a number of actions to strengthen the governance and management. In addition, a number of actions relating to positive behaviour support (regulation 7) and protection (regulation 8) had been completed or were in progress. However, it was found on this inspection that improvements were required in the adherence to procedures for positive behaviour support, safeguarding and protection and risk management. These will be discussed below.

This was a short notice announced inspection due to the nature of the respite service provided. There were no residents at Fernhill on the morning of inspection, however, three residents were due to arrive later that day. The person in charge told the inspector that the service provided had reduced due to the risks associated with the COVID-19 pandemic. However, service levels had now returned to normal levels of provision. In advance of the residents' arrival, the inspector observed the admission planning process in place. This included the organisation of staff and transport to collect the residents from their homes and a preadmission telephone call and checklist, which was completed prior to the residents' departure from their home.

Later that afternoon, two residents arrived and the inspector had the opportunity to meet with them both. One resident told the inspector that Fernhill provided a very relaxing environment and a break from the typical activities required at home. The second resident said that they loved Fernhill and commented on their feeling of freedom when staying there. They said that this was because there was plenty of support from staff and they were available when required. They said that there were no time pressures in Fernhill.

Residents were observed settling into their bedrooms and spending time in the

kitchen and living area. Some sat at the table for a cup of tea and a chat. Others sat with staff in the sitting area and watched a movie. Plans were made for a trip to town and to the cinema later that evening. The inspector observed that decisions were made by the residents in consultation with the staff. For example, the fact that they choose to eat their evening meal prior to the trip to the cinema. Interactions between the staff and residents were observed as relaxed and supportive and residents' opinions were valued and their choices respected.

There were three staff members at Fernhill on the morning of inspection. These included the person in charge, the respite house manager and a healthcare assistant. A member of staff from the physical and sensory disability team was also present throughout the day. The inspector met with two staff members and with the staff member from the administrative team. From conversations held and interactions observed, the inspector found that the provision of a high quality person-centred service and the promotion of residents' rights was important to the staff employed. For example, one staff member told the inspector that they felt it was important to collect residents from their homes as this signalled the start of their respite break. They said this arrangement afforded an opportunity to meet with the resident and their family members at their home and to speak with them. In addition, the journey to Fernhill allowed an opportunity to converse with the resident, to see how things were going and to make plans for the respite break. In some cases, the residents were reported to plan activities while on route to the centre. For example, to stop for lunch, to go to the shops or to attend a medical appointment. While at the respite service, a range of activities were provided in consultation with individual residents and their wishes. For example, one resident enjoyed choral singing and was a member of a choir. A music lesson was planned for the weekend, which would include vocal coaching.

The person in charge said that consultation with the residents and their families was paramount in order to enhance the service provided. Recently a questionnaire was circulated and opinions were sought on short break and respite options. Subsequently, a range of additional respite options were proposed and supplementary funding approved by the provider. This additional service provision was due to commence in the weeks following the inspection and included added activities in the local community as well as hotel breaks to different locations. In addition, feedback sheets were posted to residents homes after their respite break. A freepost envelope was provided and a high level of responses were received. This provided opportunities for residents to contribute to the growth and development of the service.

The house provided was accessible, spacious, and homely and appeared suitable for the needs of the residents staying there. It was welcoming and cheerfully decorated with artwork and colourful soft furnishings. There were three bedrooms in the property, one of which was en-suite and had a tracking hoist in place. The other two rooms were neat and tidy and there was a large shared bathroom close by. Smart devices were provided in the bedrooms for residents use. For example, smart lamps were on the bedroom lockers which the residents could use for voice commands and to listen to the radio or music. The kitchen and living room were bright and welcoming with some accessible kitchen units provided. There was a separate sitting

room adjacent to this that provided a quiet space for residents use if required. At the front of the property, there was a small garden area and parking facilities for the providers transport. The inspector noted that a concern identified on a previous inspection was rectified. This related to a privacy screen on a bedroom window, which was now was in place. At the rear of the property, there was an accessible garden area for residents use with a seating area provided.

In general, the inspector found that the service provided a good quality and person-centred service to residents visiting Fernhill. However, improvements in the management and oversight of positive behaviour support, safeguarding and protection and risk management would further support a safe and quality service.

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

Capacity and capability

This inspection was a follow up inspection a targeted inspection programme which took place over two weeks in January 2022 and to review actions identified by the provider as part of the overview report, as mentioned previously. An update to the compliance plan of the overview report had been requested and received by the Chief Inspector of Social Services in July 2022, and it was noted that most actions had been completed, or were in the process of being completed. In addition, the provider was required to submit monthly updates on a management improvement plan for the overall campus to the Chief Inspector since April 2021. Progress on some of these actions were also reviewed on this inspection.

During this inspection, improvements were found in the overall governance and management systems in place. However, further improvements were required. These related to improvements in governance, management and oversight in relation to positive behaviour support, safeguarding and protection and risk management. These will be expanded on below.

The management structure consisted of a person in charge who reported to the Donegal Disability Service Manager. The person in charge did not have responsibility for any other designated centre at the time of inspection. As previously mentioned, there was a respite house manager who supported the person in charge with the operational management of the centre, for example, with oversight of staff rosters, supervision and with the day to day running of the centre.

Staffing arrangements were reviewed as part of the inspection. The provider ensured that the number and skill mix of staff was appropriate for the needs of residents attending respite. Where additional staff were required this was planned for and facilitated. However, the person in charge told the inspector that this was rarely needed. The roster was reviewed and the inspector found that it was well

maintained and provided an accurate account of the staff present at the time of inspection.

Staff had access to appropriate training, including refresher training, as part of a continuous professional development programme. A staff training matrix was maintained which included details about when staff had completed training. A sample of training records reviewed demonstrated that staff members had competed the mandatory and refresher training as required. Where training was not readily available for the staff team, the person in charge provided evidence of seeking training through alternative arrangements to ensure compliance. For example, moving and handling training. A formal schedule of staff supervision and performance management was in place and meetings were up to date for the staff team, the respite house manager and the person in charge.

Through the compliance plan submitted, the provider had committed to a number of actions in relation to oversight and ongoing monitoring of the centre by the local management team and the provider. As part of this, a new schedule of audits was introduced to the Donegal services by the provider in August 2022. However, the person in charge told the inspector that this was introduced to Fernhill the week previous. The new schedule included audits in safeguarding, incidents, complaints, medicines, fire safety, finances, health and safety, restrictive practices and the use of physical interventions. The person in charge told the inspector that in some cases, the older audit tools remained in use and that the changeover was in progress. For example, the weekly fire check audit was reviewed. The inspector found that a named person was responsible for this and that the audit tool was completed in full and was up to date. However, the audit tools in relation to safeguarding and as per the provider's action plan was not fully implemented at the time of inspection.

A number of governance meetings were implemented by the provider as part of their action plan from the overview report to strengthen the oversight and management systems of designated centres. These were reviewed with the person in charge during the inspection. The inspector found that all governance meetings were established and meetings were taking place. The person in charge told the inspector that some meetings were held under the governance of the physical and sensory disability management team under which Fernhill operated. These included the Policy, Procedure, Protocol and Guidelines Development Group (PPPG) and the Governance for Quality and Safety Service Improvement meeting which was held every three months. From discussion with the person in charge it was evident that participation at the meetings scheduled afforded opportunities for shared learning to take place which was reported as beneficial to the person in charge and the service. Furthermore, on occasions that the person in charge was unable to attend, the information was circulated and available for review.

The provider ensured that unannounced six monthly audits were completed. There was one completed in July 2022, which identified a number of areas for improvement. These were either completed or in progress. The annual review of care and support provided was completed in December 2021. The centre had a quality improvement plan (QIP) which contain all actions arising from the provider

audits, inspections by the Health Information and Quality Authority (HIQA) and a self-assessment audit by the person in charge. The person in charge showed the inspector the most up-to-date QIP and spoke about actions completed and some that were in progress. For example, actions in relation to the improvement of the floor covering in the kitchen and the level access provided at the front entrance were ongoing.

A review of incidents and practices in the centre indicated that the person in charge had submitted notifications to the Chief Inspector in line with the requirements of the regulation. In addition, the provider had prepared a statement of purpose which was subject to regular review and was in line with the requirements of Schedule 1 of the regulations. A copy of the statement of purpose was available in each of the bedrooms for residents use.

Overall, the inspector found good management arrangements in the centre which led to improved outcomes for residents' quality of life and care provided. However, some improvements were required to ensure full compliance with the regulations in relation to governance, management and oversight and to ensure adherence to the action plan introduced to the service by the provider.

Regulation 15: Staffing

The provider ensured that the number and skill mix of staff was appropriate for the needs of residents attending respite. Where additional staff were required this was planned for and facilitated. The roster was reviewed and the inspector found that it was well maintained and provided an accurate account of the staff present at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training, including refresher training, as part of a continuous professional development programme. A formal schedule of staff supervision and performance management was in place and meetings were up to date.

Judgment: Compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme in January 2022, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements 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 CHO1. The inspector reviewed the schedule of meetings held with the person in charge and found that all governance meetings were established and meetings were taking place. The person in charge told the inspector that some meetings were held under the governance of the physical and sensory disability management team under which this service operated. These included the Policy, Procedure, Protocol and Guidelines Development Group (PPPG) and the Governance for Quality and Safety Service Improvement meeting which was held every three months. From discussion with the person in charge it was evident that participation at the meetings scheduled afforded opportunities for shared learning to take place which was reported as beneficial to the person in charge and the service. Furthermore, on occasions that the person in charge was unable to attend, the information was circulated and available for review. The action relating to the development of a new audit system was reviewed. The person in charge told the inspector that this was introduced recently and not fully actioned at the time of inspection.

In relation to the provider's commitment to the compliance plan as outlined above and in relation to findings during this inspection, improvements were required in the following areas:

- To ensure that the audit schedule introduced to the service is put in place

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which was subject to regular review and was in line with the requirements of Schedule 1 of the regulations. A copy of the statement of purpose was available in each of the bedrooms.

Judgment: Compliant

Regulation 31: Notification of incidents

In the case of an adverse incident occurring, the person in charge had ensured that notice was provided to the Chief Inspector in a timely manner and in line with the

requirements of the regulation

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents visiting Fernhill were supported with their needs and were provided with care that promoted their health and wellbeing. However, further improvements were required to ensure full compliance. These related to improvements in governance, management and oversight in relation to positive behaviour support, safeguarding and protection and risk management.

Residents were found to have comprehensive assessments completed of their health, personal and social needs. Residents were supported to achieve the best possible health and wellbeing outcomes. For example, where residents were required to attend medical appointments, these could be co-ordinated so that they would occur at the time of a respite break. Therefore, the residents could avail of the provider's transport and the staff support in order to attend their medical needs. Furthermore, where the support of allied health professionals was required, this was provided. For example, the occupational therapist visited Fernhill to assess the requirements for a new dining table. In addition to this, the physiotherapist had visited the centre to provide support and guidance in relation to the referral of a new resident who would be visiting the respite service.

Overall, there were good systems in place for risk management. There was a policy and procedure for risk management in place and a safety statement document which outlined emergency plans for the centre. A risk register was maintained and where risks were required to be escalated to senior management, this had been done. Residents had individual risk assessments completed if required. However, some improvements were required to ensure that all risks identified were subject to a risk assessment. For example, risks in relation to shaving as identified on a residents care plan. In addition, improvements were required to ensure that all control measures identified by the behaviour support plans were fully captured on the risk assessments in place. For example, the availability of additional staff as a control measure at times of risk if required.

Residents that required supports with behaviours of concern had behaviour support plans in place. These were reviewed regularly with the neuropsychology team and other members of the MDT as required. A log of restrictive practices was maintained at the designated centre and the inspector found that restrictions in place were the least restrictive, and used for the shortest duration necessary. However, the inspector found that two actions from the provider's action plan required improvement to ensure full compliance. These included the requirement to ensure that all staff signed residents' positive behaviour support plans to indicate that they had read and understood the contents. In addition, the induction pack used at the

designated centre required review and updating by the person in charge and their manager, in line with the requirements of the provider's action plan.

The provider had ensured that measures were in place to ensure that residents were safeguarding and protected from abuse. For example, residents were provided with information on safeguarding which was available for review in their bedrooms and on the notice boards in the designated centre. A designated officer was in place and their picture and name was prominently displayed. Residents requiring support with personal care had intimate care plans completed and staff had completed training in safeguarding and protection. However, some improvements were required in relation to one residents intimate care plan to ensure that it aligned with the recommendations made by the neuropsychologist as part of the behaviour support strategies provided. Futhermore, three actions in relation to the provider's action plan remained outstanding. These included; the policy on safe wifi provision which was reported to be progressing at national level, the requirement to attend sexuality awareness training which was due to take place the week following the inspection, and the introduction of the safeguarding audit schedule and audit tool to the service.

The provider had ensured that the premises provided was suitable to the needs of the residents accessing the service. The property was accessible and equipment the available were in a good state of repair and correctly maintained. The person in charge had systems in place to ensure that maintenance matters arising were noted, documented and addressed if required. Furthermore, concerns identified during an inspection in February 2020 in relation to the privacy arrangements in a bedroom were addressed in line with the compliance plan submitted at that time.

The provider had effective management systems in place to reduce and manage the risk of fire in the designated centre and adequate arrangements were in place to detect, contain and extinguish fires. From the sample of training reviewed, all staff had up-to-date fire training provided. A name person was in nominated to oversee the monitoring systems in place and to act as fire officer. The audits reviewed were up to date.

In summary, residents were found to be well supported with their needs and overall wellbeing. However, improvements were required in governance, management and oversight in relation to positive behaviour support, safeguarding and protection and risk management. This would further promote the quality and safety of the service provided.

Regulation 17: Premises

The provider had ensured that the premises provided was suitable to the needs of the residents accessing the service. The property was accessible and equipment the available were in a good state of repair and correctly maintained. The person in

charge had systems in place to ensure that maintenance matters arising were noted, documented and addressed if required.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies. The risk management policy was in place and a risk register was maintained. Residents had individual risk assessments completed if required. However, improvements were required as follows:

- To ensure all risks identified were subject to a risk assessment. For example, risks in relation to shaving as identified on a residents care plan
- To ensure that all control measures identified by the behaviour support plans were recorded on the risk assessments in place. For example, the availability of additional staff if required.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had effective management systems in place to reduce and manage the risk of fire in the designated centre and adequate arrangements were in place to detect, contain and extinguish fires. From the sample of training reviewed, all staff had up-to-date fire training provided. A name person was in nominated to oversee the monitoring systems in place and to act as fire officer. The audits reviewed were up to date.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health and wellbeing. Where healthcare was recommended and required, residents were facilitated to access healthcare appointments

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 relating to positive behavioural support at the centre. One action related to the approval of MDT supports, three actions related to staff training and ensuring staff have knowledge about behaviour support plans and three actions related to the induction of new staff. The inspector reviewed the actions put in place by the provider with the person in charge during the inspection and found that five actions were completed. These included an updated training matrix which was introduced to the service and the monitoring of compliance with the actions outlined at bi-monthly person in charge meetings. However, two actions remained outstanding and improvements were required as follows:

- To ensure that all staff sign residents' behaviour support plans
- To ensure that the induction pack is reviewed and updated in line with the requirement of the provider's compliance plan

On this inspection, it was evident that residents who required support with positive behaviour had behaviour support plans in place. These were reviewed with the neuropsychology team and other members of the MDT if required. A log of restrictive practices was maintained and the inspector found that the least restrictive procedure was used for the shortest duration necessary and only if required.

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 relating to protection at the centre. The inspector reviewed the actions put in place by the provider with the person in charge during the inspection. The inspector found that 10 actions were completed. These included the implementation of a peer support structure for designated officers which was facilitated by the physical and sensory disability team locally and the safeguarding training on preliminary screening which was provided during a person in charge meeting held. Three actions were outstanding. These included the action in relation to safeguarding audits which were introduced as part of a new audit schedule recently. This action was not fully actioned at the time of inspection. The action relating to the development of a policy on safe internet usage was progressing at national level. In addition, staff had not attended the sexuality awareness training planned, however four staff were due to attend on 8th November 2022. Therefore, improvement was required in the following areas:

- To ensure the policy on safe wifi provision is introduced to the service
- To ensure that all staff attend sexuality awareness training
- To ensure that the audit schedule and audit tool pertaining to safeguarding and protection is put in place

In relation to this inspection, the inspector found that safeguarding of residents was promoted and supported by staff and residents spoken with said that they felt safe. However, improvement was required in the following area:

- To ensure that residents intimate care plans were reviewed, updated and linked with positive behaviour support plans where required

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Fernhill Respite House OSV-0003338

Inspection ID: MON-0036898

Date of inspection: 03/11/2022

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure compliance with the above regulation the following has been undertaken: • CHO1 Disability Services revised audit schedule has been implemented. • All revised CHO1 audit tools are currently being implemented within the centre in line with the annual Audit Schedule. • The PIC for Fernhill Respite House has been included to group email system for Donegal PIC's to ensure all updates in relation to audit system reviews are received.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: To ensure compliance with the above regulation the following has been undertaken: • The PIC has reviewed all care plans for clients that attend Fernhill Respite House to ensure all risks identified have a risk assessment- this includes the risk identified on inspection in relation 1 client shaving. • The PIC has also reviewed the risk assessments for the 2 clients who have behavioural support plans as part of their overall Care Plan – further detail has been added to 1 risk assessment in relation to additional staff availability being a control (in the management of a specific risk) as per behavioural support plan.	
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 the above regulation the following has been undertaken:	

• On the day following the inspection all staff read and signed the relevant behavioural support plans for clients. • The staff induction pack for new staff members has been reviewed and updated in line with the CHO1 Donegal overall compliance plan submitted in April 2022.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: To ensure compliance with the above regulation the following has been undertaken: • Fernhill Respite currently has a local policy in place since the introduction of wifi to the house in 2019, however await a revised National policy on the safe use of Wifi. • In relation to sexuality awareness training 4 staff members have completed this in November 2022- it is planned that the other 2 staff members will have this training completed by 28.02.2023. • The revised audit schedule for CHO1 has been implemented and the new audit tool has been implemented in relation to safeguarding and protection and will continue to be as part of the schedule. • The intimate care plans of 2 clients have now been reviewed. • All clients intimate care plans are updated as part of an annual assessment and care plan and as required. As part of a review of current intimate care plans, the plan for 1 client has now amended and linked with the behavioural support plan, detailing that an additional staff member should be available when this client is being supported with showering.

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	10/11/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	25/11/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Substantially Compliant	Yellow	10/11/2022

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/03/2023