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:	Sunbeam Lodge Community Group Home
Name of provider:	Health Service Executive
Address of centre:	Leitrim
Type of inspection:	Short Notice Announced
Date of inspection:	14 January 2025
Centre ID:	OSV-0001932
Fieldwork ID:	MON-0044463

About the designated centre

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

Sunbeam Lodge Community Group Home is a bungalow situated in a busy town close to all community amenities. It currently provides full-time accommodation to female adults with a moderate to profound intellectual disability and a range of high support needs. The house is staffed by nurses and healthcare assistants. A waking night-time arrangement is in place. The centre comprises of three bedrooms (one of which is en suite), a bathroom, kitchen, utility room, dining room and sitting room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 14 January 2025	11:00hrs to 18:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This inspection was the first inspection of a centre that was registered under a new provider on 29 July 2024. Its purpose was to monitor the transition to the new provider and to review compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013).

At the time of inspection, it was five months since the changeover took place. The inspector found that good quality healthcare support was provided by a dedicated staff team. However, significant improvements were required in order to protect residents' rights, support those with behaviours of concern and manage compatibility and other risks arising at the centre. In addition, the overall governance and management arrangements at the centre required strengthening.

On arrival at the centre, the inspector met with the staff on duty. The person in charge was on leave and the inspection was facilitated by a staff nurse and the staff team. The person participating in management came to the centre later in the afternoon to support the process.

The atmosphere was warm, welcoming and calm. There was one resident at home and they were observed moving from their bedroom to the kitchen and sitting room as they wished. They had music playing on a television in their bedroom. When this stopped, the resident expressed their wish to have it on again. This was acted on promptly. The inspector noted that transport was available for the residents use and sufficient staff were on duty. However, it was clear that the resident wished to remain at home. They appeared content with the inspector's presence, however, they did not engage with them and this was respected.

The second resident arrived home from their day service later in the afternoon. They were welcomed by staff and interactions were observed as kind and supportive. The resident completed a routine such as putting their bag and coat in their bedroom and preparing to eat. However, they liked to express their feelings and they would exclaim loudly from time to time. The inspector noted the change in the environment when both residents were present together. Later, this resident sat with the inspector while they looked at photographs on their tablet device. These included pictures of their friends and of parties they attended.

The inspector completed a tour of the centre and found that actions required following the July 2023 inspection were completed. This included the replacement of the heating system and the installation of a new hydrotherapy bath as recommended by allied health professionals at that time. Staff told the inspector that while they were concerned about the resident's acceptance of a new bathing routine, it worked out very well. They said that the resident loved their new bath and as they spoke, the resident was observed smiling widely. Staff told the inspector that the resident could use the bath functions independently and that its use enhanced their day to day life as their home based activities were limited. The

inspector noted soft coloured mats on the floor which the resident sat down on and a smart speaker for music on the wall.

A further tour of the premises found that the bedrooms provided were decorated in line with the resident's preferences. One room was en-suite and it was clean and tidy. Staff told the inspector that they had a plan to enhance the second bedroom by providing a seating area for the resident to use instead of the bed if they wished. Items of interest to residents were displayed and these included a sensory board and a sensory box in the sitting room. These were recommendations of the multi-disciplinary team. Two sitting rooms were provided. The main sitting room was at the front of the building. A second smaller sitting room was provided since the last inspection. This had a trolley with facilities to make hot drinks provided. Staff explained that this was used by a resident during times that they could not access the kitchen facilities. This will be expanded on later in this report.

The dining room was spacious but sparsely decorated. The kitchen was a long narrow space with a hatch-style opening to the dining room. It did not meet with the needs of the residents living at Sunbeam Lodge and the provider was aware of this. A plan was in place to change this area to an open plan kitchen and dining room. This will be expanded on later in this report.

Staff spoken with told the inspector that they had completed training in human rights. They were aware of the importance of a rights based service and spoke of respect for individuals in their own right. They spoke of compatibility issues arising at the centre and how ongoing work was required in order to support individual rights and to keep people safe.

The next two sections of this report will outline the findings of this inspection in relation to the governance arrangements in place in the centre and how these impacted on the quality and safety of the service.

Capacity and capability

As outlined, this service changed to a new provider in July 2024. The person in charge remained in post which meant that consistent leadership arrangements were in place. As part of the changeover, new management systems were introduced and the documentation changeover was progressing at the time of inspection. However, action was required in order to address significant concerns relating to residents' rights, positive behaviour support and risk management in order to improve the service provided.

Following registration, the provider prepared a statement of purpose; however, it required review as it did not contain the information as set out in the certificate of registration.

The person in charge was employed full-time and had responsibility for another

designated centre on the same campus. They had the required skills and experience which met with the requirements of the regulation.

A review of staffing arrangements found that the number, qualifications and skill mix of staff employed at the designated centre was appropriate to the number and assessed needs of the residents living there. While staff employed had access to training as part of a professional development programme, not all refresher training was up to date and this required improvement. This will be expanded on under the regulation below.

The inspector found that the centre was well resourced with adequate staffing, access to transport and where equipment was recommended by the multi-disciplinary team, this was in place. However, suitable internet access was not provided at the time of inspection. This impacted on the ability of the person in charge to carry out their role efficiently. The new provider audit schedule was prepared for 2025. Ongoing work was required to ensure that audits were effective in identifying gaps in the quality of the service provide and that actions identified were on the centre's quality improvement plan. The annual review of care and support and the six-monthly provider-led audit were not yet due.

Overall, the inspector found that good quality care and support was provided by the staff employed. However, the inspector was not assured that the rights of residents were adequately protected and that positive behaviour support and risk management arrangements were effective. In addition, improvements in staff training, enhancement of the premises and overall governance and management would further enhance the service. The next section of this report will review the quality and safety of the care and support provided.

Regulation 14: Persons in charge

The provider had a person in charge who had the appropriate qualifications, skills and experience and met with the requirements of the regulation.

Judgment: Compliant

Regulation 15: Staffing

The provider ensured that the number, qualifications and skills mix of staff employed at the designated centre was appropriate to the number and assessed needs of the residents living there.

Where nursing care was required, this was provided in line with the statement of purpose.

Where staff were employed on a less than full-time basis, the provider ensured that continuity of care and support was provided. The inspector met with an agency staff nurse on the day of inspection. They were very familiar with the residents, their support needs and the day to day operation of the centre.

The inspector reviewed a sample planned and actual rota from 2 December 2024 to the date of inspection (14 January 2025). Improvements were required to the actual rota as it did not provide an accurate reflection of the staff on duty on the day of inspection. This included the updating of staff attendance to reflect a staff member on duty and a staff member on leave. This was corrected prior to the departure of the inspector.

Judgment: Compliant

Regulation 16: Training and staff development

While staff had access to a range of training and development options and systems to record and monitor attendance were in place, a review was required to ensure that all modules for all staff were up to date.

The inspector reviewed a sample of mandatory training modules for four staff members. The modules reviewed included fire safety, positive behaviour support and safeguarding of vulnerable adults. The staff sample included one nurse and three healthcare assistants. Three were core staff members and one was employed by an agency.

This review found:

- A staff nurse on duty and a healthcare assistant on duty did not have up-to-date refresher training in positive behaviour support.
- A healthcare assistant did not have up-to-date refresher training in fire safety
- In addition, the arrangements to ensure that staff received formal support through a supervision process required review. Dates for the completion of appraisal meetings were provided for two of the four requested. Therefore, although reported as complete, this information was not readily available in the centre on the day of inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider retained the original governance arrangements which were

in place prior to 29 July 2024. This meant that consistent leadership was provided during the time of change. The person in charge continued to have responsibility for another designated centre and a separate non-regulated service on the same campus. The inspector acknowledged that the person in charge had a range of governance responsibilities with tasks associated with the change in provider to be completed. The provider was aware of this and they had a plan in place to address these matters which was progressing at the time of inspection. The progression of this plan would enhance the service provided.

In addition:

- The inspector found that the centre was well resourced with adequate staffing and access to transport was provided. Where equipment was recommended by the multi-disciplinary team, this was in provided. However, resources relating to information technology required improvement as the service was yet to be connected to the provider's internet network. This impacted on the governance and management arrangements in the centre.
- A review of the compatibility arrangements in the centre was required. Although a data gathering exercise was completed on regular basis by the staff team, there was no system in place to ensure that the information gathered was of use.
- The new provider audit schedule was prepared for 2025. Ongoing work was required to ensure that audits were effective in identifying gaps in the quality of the service provided and that actions identified were on the centre's quality improvement plan. For example, gaps in training provided, improvements in positive behaviour support arrangements and gaps in risk management systems.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which required improvement in order to meet with the requirements of Schedule 1 of the regulation.

For example:

- The statement of purpose prepared on 28 June 2024 did not contain the information as set out in the certificate of registration.

Judgment: Substantially compliant

Quality and safety

During the course of the inspection, the inspector met with both residents and spoke with all staff members on duty. It was clear that the quality of care provided to residents was a high standard and improvements to the premises further enhanced the day to day lives of the residents living at Sunbeam Lodge. While this was the case, significant concerns relating to residents rights, positive behaviour support and risk management were found. Furthermore, ongoing work was required to the premises, to training and development arrangements and to overall governance and management systems to ensure that they were effective and provided clear guidance to the staff employed.

The premises comprised a bungalow located on a shared campus. Improvements since the last inspection included new floor coverings, improved heating systems, improved bathroom facilities which included the hydrotherapy bath and the provision of a new sitting room for one of the residents. Ongoing improvements to the kitchen space was required and a plan was in place to progress this.

Residents living at Sunbeam Lodge had access to good quality healthcare support which was facilitated by a knowledgeable staff team. Residents had a range of high support needs and appointments with healthcare professionals were arranged and facilitated in line with their individual needs. Where safeguarding concerns arose, staff were aware of what to do and improvements in the safeguarding process were evident at the time of inspection.

Those that required support with behaviours of concern had access to behaviour support specialists; however, improvements were required with staff training and streamlining of documentation. In addition a review of risk management arrangements was required to ensure they were in line with the provider's policy and that risks identified were mitigated against.

Regulation 17: Premises

A review of the premises provided found some shortfalls with the layout of the centre. These matters were linked to the compatibility issues reported on and the inspector found that the provider had a plan to modify the premises accordingly.

For example:

- While a kitchen with suitable cooking facilities was provided, it was a very small space. One resident liked to sit in there and as reported, this impacted on the other. The provider planned to remove the wall between the kitchen and the dining room in order to provide an open plan space. This plan required completion.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management processes were not clear and consistent in this centre. The processes for identification, assessment and management of risk required improvement. While the provider had a risk management policy and safety statements, practices in the centre were not in line with guidance provided.

For example:

- Risks were identified but were not risk assessed. A risk was identified in a positive behaviour support plan (9 October 2024). This related a resident spending too much time using the hydrotherapy jets in the bath as they had with epilepsy. In addition, as they enjoyed the bath, they found transitions out of it difficult which increased the risk. While there was a general risk assessment for the use of the hydrotherapy bath, it did not include the risks relating to epileptic seizures.
- Where risk assessments were completed, the control measures were not always specific to the risk identified and were not always effective. A risk assessment relating to the risk abuse from a peer dated 4 October 2024 signposted control measures not relevant to the risk identified. The residents safeguarding plan was not identified as a control measure.
- Compatibility of residents was identified by the provider and the staff team as a key operational risk in this designated centre. An assessment tool for the evaluation of interpersonal compatibility was completed by staff on a regular basis. The inspector completed a lookback review on assessments completed from 16 January 2024 to 20 December 2024. Although a large amount of data was collected, it did not appear to have a purpose. It was not reviewed, evaluated and did not inform any actions at the time of inspection.

Judgment: Not compliant

Regulation 6: Health care

This service had a proactive model of care delivery that was centred on the individual healthcare needs of the residents. The provider and the person in charge ensured that the health and wellbeing of each resident was promoted and supported by the staff team.

Residents had access to a general practitioner (GP) in the locality. From discussions with staff and review of the documentation, it was evident that every effort was made to ensure that the GP was aware of residents' needs. The inspector found that all reasonable adjustments were made to ensure that health assessments were the

least stressful possible and therefore increased likelihood of effectiveness.

Residents had access to allied health professionals if required and appointments took place in clinic and in the residents' home. This included speech and language therapy, occupational therapy, community nursing specialists (tissue viability) and chiropody.

Residents had access to consultant-led care if recommended. This included neurology, urology and mental health and intellectual disability support.

Where decisions regarding the residents healthcare needs were required, their representatives were involved through in person meetings with healthcare professionals.

Overall, there was a holistic and co-ordinated approach to the social, emotional, psychological and spiritual care of residents. Staff spoken with were aware of residents changing needs and the needs for forward planning to ensure their needs are provided for now and into the future.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents living at this centre had a range of complex behaviour support needs. While care was delivered to a high standard, there were gaps in staff training and in the documentation held at the centre which impact on the findings of this regulation.

The inspector was not assured that the positive behaviour support arrangements were effective.

For example:

- While staff had mandatory training in positive behaviour support, not all refresher training modules reviewed were up to date.
- A review of behaviour support plans was required to ensure that they provided clear guidance, included up-to-date information only and were easy to comprehend. A plan reviewed was dated 2017, with updates added over a 7 year period. This included proactive strategies such as table seating plans which were obsolete as staff reported that the resident liked to eat alone. In addition, the offering of finger foods which were on longer recommended due to risk of choking.
- A further review was required to ensure that behaviour support plans were readily available at the centre as one plan was not available in updated form in the residents file. It was located later in the afternoon in another building on the campus.

Judgment: Not compliant

Regulation 8: Protection

The residents living at this centre had a range of support needs which are outlined throughout this report and there were safeguarding and protection risks at the centre.

A review of this regulation found that the staff team were aware of their responsibilities in relation to protecting residents from abuse. They were aware of the identity of the designated officer and of what to do should a concern arise. There were no open safeguarding risks at the time of inspection. A review of past concerns found that they were documented in line with local and national safeguarding policy and safeguarding plans were in place.

While staff had completed mandatory training in safeguarding, not all refresher training was up to date. This is reported on under Regulation 16: Training and Staff Development.

In addition, the registered provider was aware of compatibility matters arising and of the possible risks to the protection of residents. The high level of staff support provided ensured that residents had good levels of care, support and supervision which reduced safeguarding risks. Matters relation to compatibility of residents are reported under Regulation 9: Residents' Rights.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector was not assured that all residents had opportunity to exercise choice and control in their daily life or the freedom to use all areas of the designated centre in accordance with their wishes. As outlined, residents living at this centre had a range of support needs and there were issues relating to the compatibility of those living together.

For example:

- On 20, 21 and 22 October 2024, it was reported that a resident was unable to access the small kitchen provided as their peer was sitting on the floor. On 21 October 2024 this was reported to be for a period of two hours.
- On 21 October 2024, it was reported that the same resident was asked to leave the sitting room as their peer almost sat on them. They were encouraged to return but asked to leave again as their peer had removed their clothing. A review of documentation found that this had a significant

impact on the resident who was reported as not interactive, going to their room and sitting on their bed rather than getting in to bed to sleep. This was described as unusual behaviour and staff documented that they were concerned for the resident's wellbeing.

- In addition, on the night of 20 October 2024, it was reported that sweets were found in the resident's locker. These were removed and placed in safekeeping without the residents consent. When explored with staff, they expressed concern about the risk of choking. This was not documented on a risk assessment at the time of inspection.
- The inspector acknowledged the alternative tea and coffee facilities for the resident which were provided in a separate sitting room; however, it was clear that the routines, practices and facilities provided did not promote the autonomy, choice and independence for all.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sunbeam Lodge Community Group Home OSV-0001932

Inspection ID: MON-0044463

Date of inspection: 14/01/2025

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In order to come into compliance with Regulation 16 the following actions will be completed: • The CH CDLMS training matrix has been implemented within the Centre and outlines the schedule for all, mandatory and site-specific training. The PIC will ensure this training matrix is reviewed and monitored weekly in order to ensure compliance. • Quarterly compliance reports are completed for the Registered Provider in respect of training from a governance perspective. • Refresher training for two staff members in positive behaviour support has been scheduled for March 2025. This will be completed by 28.03.2025. • Fire Safety training has been provided for one staff member who was out of date with this training. This was completed on the 17/01/2025 • A schedule for all staff supervision has been developed for 2025 as per Schedule 2 requirements. The PIC will ensure the supervision is completed for all staff and a record is maintained within the designated centre. Five staff supervisions have been completed to date for 2025.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to come into compliance with Regulation 23 the following actions will be completed: • A new Person in charge has been appointed to the service which will provide the	

necessary governance and management structures within the service. This was completed on 03/02/2025.
• Staff within the centre will have access to HSE computer system and emails through installation of the HSE Network. This will be completed by the 31/03/2025
• A full review of all compatibility assessments that have been completed to date was carried out by relevant members of the multidisciplinary team. Going forward all data gathered will be reviewed continuously and this will be documented to inform residential placements and service delivery. The Sligo Leitrim Disability Services new compatibility assessment 'Co-Residential Living – Evaluating for interpersonal Compatibility for Shared Experiences' will be utilised within the service to gain further information to guide residential placements. The use of this tool commenced on the 24/02/2025.
• The CH CDLMS Audit Schedule is now fully operational within the service. All actions identified through audits undertaken will be included on the centres Quality Improvement Plan and monitored until closed out within identified timeframes. Senior management will provide ongoing governance and monitoring of all actions identified on the centres QIP.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

In order to come into compliance with Regulation 3 the following actions will be completed:

• The statement of purpose has been reviewed and revised to include information as set out in the certificate of registration. Date Completed: 18/02/2025

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

In order to come into compliance with regulation 17 the following actions will be completed:

• A technical review of the centre has been requested by the HSE Estates Department. This will be completed by 31/03/25.
• The plan in place to remove a partitioning wall between the kitchen and the dining room which will create an open plan kitchen/ dining room and facilitate residents to have free access to the kitchen will be completed by 31/03/2025.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

In order to come into compliance with Regulation 26 the following actions will be completed:

• The 2023 HSE Enterprise Risk Management policy and procedures has been implemented within the service.

• The service is reviewing and updating each residents individual risk assessments. This will be completed on 07/03/2025. As part of this review the Sligo Leitrim revised risk assessment template will be used to document each risk and set out control measures etc. Once updated these will be kept under continuous review.
• Additional training for staff in the area of risk management has been scheduled for March 2025. This will be completed by 31/03/25.
• The risk identified in a positive behavior support plan on the 9th October 2024 in relation to a resident with epilepsy spending too much time using hydrotherapy jets in the bath is been reviewed. A risk assessment is now in place for the use of the hydrotherapy bath,for residents with epilepsy. This was completed on 24/02/2025
• The safeguarding risk assessment pertainent to one resident has been reviewed and now includes all relevant control measures.
• A full review of all compatibility assessments that have been completed to date was carried out by relevant members of the multidisciplinary team. Going forward all data gathered will be reviewed continuously and this will be documented to inform residential placements and service delivery. The Sligo Leitrim Disability Services new compatibility assessment 'Co-Residential Living – Evaluating for interpersonal Compatibility for Shared Experiences' will be utilised within the service to gain further information to guide residential placements. The use of this tool commenced on the 24/02/2025.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

In order to come into compliance with Regulation 7 the following actions will be completed:
• The Sligo Leitrim Policy on Positive Behaviour Support has been implemented within the centre this has been brought to the attention of all staff.
• Two staff who require refresher training in managing behaviors of concerns have been scheduled to complete same in March 2025.This will be completed by 28.03.2025
• The CNS in Behavior is scheduled to review one residents positive behavioral support plan on the 28/02/2025. All proactive strategies which are outdated will be removed.
• The PIC will ensure that residents behavior support plans are available as part of the overall residents care plan within the centre. Completed on 16/01/2025.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

In order to come into compliance with Regulation 9 the following actions will be completed:

• All staff within the designated Centre have completed the following courses- Applying a Human Rights- based Approach in Health and Social Care: Putting National Standards into Practice- Module 1 – 4.
• The plan in place to remove a partitioning wall between the kitchen and the dining room which will create an open plan kitchen/ dining room and facilitate residents to have

free access to the kitchen will be completed by 31/03/2025
• Going forward any incidents where residents rights are impacted as a result of an will be reviewed immediately by the PIC and relevant members of the MDT
• A daily review of all care notes and associated documentation has commenced within the centre by the PIC to ensure all residents human rights are respected and promoted within the centre. One resident has been referred for psychological support on the 27th February 2025.
• One resident has been referred to the Speech and Language service for a swallow assessment due to a choking concern.
• Going forward each resident will be consulted with in relation to all decisions related to them and this has been discussed with all staff.
• Restrictive Practices will be referred to the Human Rights Committee for consideration. Documentation relating to Restrictive Practices will be maintained in line with the HSE Restrictive Practice Policy. This will be completed by 14/03/2025
• Residents meetings are conducted weekly. Resident's human rights to be included for discussion be discussed at meetings. Easy read materials in relation to human rights will be made available for each resident and staff will support residents to understand this information.
• Resident's choices will also be included for discussion at residents meetings with easy read materials made available for each resident to ensure they comprehend information on their right to choose.
• Each resident's assessment of need and person centered plan is currently been reviewed. This will be completed by 28/02/2025

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	28/03/2025
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.	Substantially Compliant	Yellow	31/03/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Substantially Compliant	Yellow	31/03/2025

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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.	Not Compliant	Orange	31/03/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	18/02/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	28/02/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the	Not Compliant	Orange	31/03/2025

	freedom to exercise choice and control in his or her daily life.			