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:	Thornvilla Community Group Home
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Short Notice Announced
Date of inspection:	05 February 2025
Centre ID:	OSV-0001936
Fieldwork ID:	MON-0044462

About the designated centre

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

Thornvilla Community Group Home provides full-time residential care and support to adults with an intellectual disability. The centre can accommodate male and female residents over the age of 18 years.The centre comprises of a two-storey detached house set in its own grounds in a residential area of a town. The centre is in close proximity to a range of local amenities such as public transport, cafes, cinema and shops. Residents also have access to a vehicle at the centre to support them to access other activities and amenities in the surrounding area. In addition to their own bedrooms, residents living at the centre have access to community facilities which include a sitting room, kitchen and dining room. In addition, a large communal bathroom is available on each floor of the building. Residents are supported by a team of care assistants, with staff available during the day to support residents when they are not at their day service. At night-time, there are sleepover staff and waking night cover provided to support residents with their needs. In addition, the provider has arrangements in place to provide management support to staff outside of office hours and at weekends.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 5 February 2025	11:00hrs to 18:00hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

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

Six months had passed since the changeover to the new provider and the inspector found that the residents and the staff team were adapting well. There were improvements to the quality and safety of the service provided some of which were ongoing at the time of inspection. These will be outlined in further detail throughout this report. However, a review of the suitability of the premises for all residents was required, along with a strengthening of staffing provision and training, and the completion of a planned upgrade to fire doors. These would further enhance the service provided to the residents living at Thornvilla.

There were five residents living at this centre at the time of inspection. The inspector met with all of them during the day. In addition, the inspector met with a resident family member who when asked, agreed to speak with them. They told the inspector that they were happy with the service provided, that their relative was also happy and that they were well cared for.

One resident who was sitting at the table having a cup of tea and morning snack. While greetings were exchanged, they did not hold a long conversation with the inspector. The dining room contained shelves with files, a small desk and two large refrigerators. Therefore, the circulation space provided was limited. There was a kitchen next door which was well equipped. The sitting room was at the front of the house. The inspector saw that the fire place was removed, the space filled in and chimney breast and mantle decorated. Staff said that this meant the room was warmer. Work to finish the hearth area was ongoing but did not appear to pose a risk at the time of inspection. In addition, a new suite of furniture was provided in this room.

Some residents invited the inspector to visit their bedrooms which were personally decorated and welcoming. One room required a repair to the saddle board and a plan was in place to progress this. The inspector found that the upstairs bathroom was renovated since the last inspection. The wall and floor coverings were replaced and new fixtures fitted. The bath was removed and replaced with a shower which the residents were reported to prefer. This meant that a more suitable and safer showering space was provided for residents which was closer to their bedrooms on the first floor.

Two residents had bedrooms on the ground floor. One was sleeping and observed to be comfortable in their bed. The person in charge spoke about a recent decline in the resident's health and wellbeing. They said that the supports provided were under regular review to ensure that were suitable for their needs. The inspector

found that while cosy, the bedroom provided was small and limited space was available for the additional mobility equipment provided. The resident had a safety device beside their bed which was used to alert staff if they required assistance. This was reported to work well. A protocol was in place and it was only used as required. These times were documented. A review of the bathroom downstairs found that it was in a poor state of repair. Wear and tear was evident on the walls and floor coverings. The person in charge said that a similar renovation was planned for this room. This would enhance the comfort of the residents using the downstairs facility.

Outside, there was a large garden area with plenty of parking space. Some of the residents spoke with the inspector about gardening. A polytunnel was provided, along with raised beds where winter vegetables were growing. At the rear of the property, there was a large standalone building known as 'the club'. This contained laundry facilities for the residents.

Later in the afternoon, the inspector met with three residents as they returned home from their daily activities. They were observed moving about their home freely and completing their individual evening routines. The inspector spent time sitting in the sitting room with some residents. Some held short conversations, saying that they were happy in their home and that they felt safe. One spoke about a recent resident's engagement forum that was held with the HSE and the Authority. They said that they enjoyed this very much and that spoke about some ideas of how we could meet again.

Sufficient staff were employed at the centre on the day of inspection. The inspector met with all of them. When asked they told the inspector that they had completed training in human rights. They were aware of the importance of a rights based service and gave examples of promoting choice of what to eat and making decisions about what to do. In addition, the inspector spoke with the person in charge. They spoke about their role in the leading a rights based service and referred to the FREDA principles as a basis for rights based care. It was clear that they had a good understanding of these principles and were motivated to embed them in the service provided.

In summary, Thornvilla provided a good quality service for the five residents living there. The staff team were observed to be kind and caring, and interactions with residents were respectful. As outline, the resident at this centre were aging and one resident had a decline in their health and wellbeing since the last inspection. This meant that adjustments were required to the service offered in order to ensure that it was suitable for their needs. This included the provision of nursing staff and appropriate living space in order to facilitate the additional equipment required. In addition, the provider completed an audit of the centre and identified improvements required to the fire containment systems. This required progress. Finally, although staff training records were well maintained, not all staff had completed mandatory training in line with the provider's requirements.

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 part of the changeover to the new provider, a range of management systems were introduced and the documentation changeover was progressing at the time of inspection. While some systems were embedded and working well, others such as the assessment of need took time and were in progress. Some required nursing assessments and the provision of nursing staff at the centre would address this. This will be expanded on under Regulation 15 below. In addition, a review of training arrangements and an assessment of the suitability of the premises for all residents would further enhance the service provided.

There was a new person in charge in Thornvilla since the last inspection. While they were new to the position of person in charge, they were not new to the service. This meant that they were familiar with the staff team, the residents and their families. They were employed full-time and had the skills and experience necessary for Regulation 14. The inspector found that they had support from the provider representatives. This included a 'buddy system' with a person in charge from another centre and on-site staff nurse support which was provided when available. The combination of these factors meant that the leadership arrangement in the centre was working well.

Following registration, the provider prepared a statement of purpose. This required review as it did not contain the information as set out in the certificate of registration. This was amended on the day of inspection.

Staffing arrangements at the centre were under ongoing review. The provider identified a need for nursing care and a recruitment campaign was ongoing but not yet successful. In the interim, healthcare assistant staffing ratios were increased during the day and night-time.

Staff employed had access to a training programme which included core and refresher training modules. A review of this found that not all staff had completed mandatory training as set out by the provider.

The inspector found that the centre was well resourced with access to transport and where equipment was recommended by the multi-disciplinary team, this was in place. The new audit schedule was prepared for 2025 and the quality improvement plan was well maintained. The annual review of care and support was not yet due. The six-monthly unannounced provider-led audit was pending. A review of incidents at the centre found that they were notified to the Chief Inspector in line with the requirement of the regulation.

Overall, the inspector found that good quality care and support was provided by the person in charge and the staff employed. However, action was required to address

gaps in training and development and to continue to secure nursing support in order to reach compliance in these regulations.

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 this regulation.

Judgment: Compliant

Regulation 15: Staffing

While a high level of staffing support was provided, ongoing work was required in order to recruit the correct skills mix required to run the service. The provider identified this need and were working to achieve the required standard. This will be expanded on in the bullets below.

A review of the planned and actual roster from the 1 January 2025 to the date of inspection was completed. It was well maintained and provided an accurate account of the staff on duty on the day of inspection.

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.

Staff had access to supervision meetings with their line manager and meetings were documented. A sample of meeting records found that they were up to date.

However:

- As outlined, a resident living at Thornvilla was experiencing a decline in their health and wellbeing. The provider identified a need for 2.5 whole time equivalent nursing support in order to meet with the assessed needs and to complete the nursing assessments at the centre. A recruitment campaign was ongoing at the time of inspection. In the interim, additional healthcare assistants were allocated and staff nurse hours were allocated when available. Ongoing work was required to meet with the target nursing need identified.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The new registered provided had introduced arrangements which were used to document training attended and to identify when training was due. The inspector found that the person in charge was familiar this matrix and it was maintained to a high standard. However, not all training was completed in line with the provider's policy and this required review as follows:

- A staff member required refresher training in positive behaviour support as it had expired on 18 January 2022. This was identified under a review completed by the person in charge under the new provider's arrangements. A plan was in place for the completion of this training in March 2025.
- Three staff members required stage one refresher training in infection prevention and control and health and safety which were to be completed by the relevant staff via an online platform.

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. In addition:

- Access to transport was provided, and the residents had use of an additional vehicle since the last inspection. This meant that had increased opportunities to access their communities.
- The registered provided introduced a new audit schedule to the service and the person in charge had an audit calendar prepared for 2025. The inspector found that in the main, the audits were effective in identifying deficits in the service and that these were documented on the quality improvement plan for the centre.
- The annual review of care and support for residents at the centre was not yet due. A plan was in place for the completion of the six-monthly unannounced provider led audit.
- The inspector found that while the centre was well resourced with staffing numbers, the skill mix of staff required review. This was ongoing as reported under Regulation 15 above.
- Where equipment was recommended by the multi-disciplinary team, this was in provided. However, space in the centre was limited and this impacted on the provision of aids and appliances. This is reported on under Regulation 17

later in this report.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which on review did not contain the information as set out in the certificate of registration. This was amended on the day of inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of incidents occurring in the centre found that notifiable matters were submitted to the Chief Inspector of Social Services in a timely manner and in line with requirements.

Judgment: Compliant

Quality and safety

The residents living in Thornvilla were provided with person-centred care and support by an experienced and dedicated staff team. The provider was aware of gaps in the service which were related to the changing needs of some residents. For example, the premises did not meet with the needs of all residents at the time of inspection and an upgrade to the fire doors was ongoing. In addition, the provider had identified the need for nursing care at the centre. While they had a plans in place to address these matters their timely progression would enhance the quality of the care and support provided.

Residents had assessments of their health, personal and social care needs. These assessment were being updated at the time of inspection and transferred to the new provider's format. Those reviewed were comprehensive and provided good guidance for the staff team. Where healthcare support was required, appointments were facilitated. This included visits to the general practitioner (GP), meeting with a range of allied health professionals and the support of consultant-led care when required. Where recommendations were made, there was evidence that they were followed. This was an improvement on the last inspection.

Residents that required positive behaviour support had this provided by a behaviour support specialist. There was one restrictive practice used at this centre, this was described as a therapeutic intervention and the inspector found it was used for the shortest duration possible and only as required. Where safeguarding concerns arose, staff were aware of what to do and improvements in the safeguarding process were evident at the time of inspection.

There were no open safeguarding concerns at the time of inspection. A look back review found that those completed in the past were in line with local and national policy. Staff training in safeguarding and protection was up-to-date and those spoken with were aware of what to do should a concern arise.

The provider had a range of risk management arrangements in place. These included a service level and centre level safety statement and a risk register for the centre. In addition, residents had individual risk assessments which were integrated with their overall plan of care.

There were improvements to the premises since the last inspection, however, ongoing work was required to return to full compliance. This was linked to the changing needs of a resident and the ongoing upgrading of bathrooms and fire containment arrangements.

Overall, this was good service that was going through a time of change. There were good governance and leadership arrangements in place and appropriate support provided. Where there were gaps in the service, the provider was aware of them and had a plan in place to progress them. This plan required acceleration in order to ensure that the service provided to all residents was in line with their changing needs and safe.

Regulation 17: Premises

A review of the premises provided found improvements since the last inspection. The registered provider had completed an audit of the property and there was evidence of ongoing improvements and upgrades to the building. These included an upgrade to the electrical systems provided, replacement of hard and soft furnishings and the renovation of the upstairs bathroom. The latter meant that there was improved access to showering facilities for the residents which they were reported to enjoy.

However, some shortfalls with the layout of the centre remained as follows:

- The premises was not suitable for the assessed needs of all residents. This was linked to the decline in the health and wellbeing of a resident who had a small bedroom on the ground floor. The provider was aware of this and as outlined, had a plan in place to improve the living arrangements for this resident in accordance with their needs. This required ongoing work to ensure that improved living accommodation was provided in order to meet

with their assessed needs.
- The bathroom on the ground floor was in a poor state of repair. Likewise, this was identified by the provider and a renovation similar to that completed in the first floor bathroom was intended.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a range of risk management arrangements in place. These included a service level and centre level safety statement and a risk register for the centre.

- Where residents had their updated assessment of needs completed, these included a primary risk screening process which provided a summary of risks which required control measures. A review of residents' risk assessments found that they were clear, comprehensive and integrated with other documents such as behaviour support and safeguarding plans if required.
- Plans were in place to respond to emergencies that may arise. For example, the inspector reviewed the provider's response to the risks posed by a significant national weather alert in January 2025. This included a discussion with maintenance personnel that was at the centre of the day of inspection. They described an overnight monitoring arrangement used, an advanced planning approach and a readiness to response when safe to do so. Subsequent actions were taken to address deficits which included the facilities required to plug in a power generator if required. This was located at the front of the premises. This showed that the emergency plans were effective and that learning from such experiences was action in order to reduce similar risks in the future.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had fire safety management systems in place including arrangements to detect, contain and extinguish fires and to evacuate the premises. The fire prevention policy was up to date and all staff had mandatory and refresher fire training completed.

Residents were provided with personal emergency evacuation plans. Staff employed were familiar with these and with the building and with the escape routes to follow if required.

Fire drills were competed on a regular basis, and both daytime and night-time scenarios were used. Safety checks were taking place regularly and the information was recorded.

Bespoke face to face fire training was arranged this year. Staff were provided with an opportunity to simulate evacuations using the new provider's guidance during this training.

However, other work was required in order to reach full compliance as follows:

- While fire doors were provided, these were subject to a review and an upgrade as identified by the provider. Ongoing work was required to complete this action in order to strengthen the fire safety arrangements in place.
- As outlined, one resident had changing needs and additional day and night time staff were provided. At the time of the inspection, the evacuation arrangements for this resident were subject to ongoing review, taking into account the mobility needs of the resident and the space provided.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had assessments of their health, personal and social care needs. These assessment were being updated at the time of inspection and transferred to the new provider's format. For example:

- Two out of five assessment were completed. Residents with high level risks were prioritised for review. Those completed were comprehensive and provided good guidance for the staff team.
- Residents had person-centred plans which documented their goals and aspirations for the year ahead. One resident liked to stay at home which was respected. However, as they enjoyed outdoor work, they were having taster session with a social farming programme to see if they would enjoy it.
- A second resident had an up to date personal plan with pictures included. This included plans to go to for a spa day and at a later date to go for afternoon tea.

Judgment: 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 proactively by the staff team.

- Residents had access to a general practitioner (GP) in the locality and to a team of allied health professionals in accordance with their needs. These included advanced nurse practitioners and clinical specialists, occupational therapy, physiotherapy and speech and language therapy. Where recommendations were made there was evidence that these were actioned accordingly. For example, it was recommended that a resident be referred to a specific support service (mental health occupational therapy) and this was completed.
- In addition, residents had access to consultant-led care if recommended.
- Where decisions regarding the residents healthcare needs were required, their representatives were involved through in person meetings with healthcare professionals. The person in charge had a family meeting planned for the week of inspection. This meant that a collaborative approach to care was promoted.

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

Some residents at this centre required positive behaviour support and they had access to specialists in this area.

- One behaviour support plan was reviewed on 28 January 2025 as the person in charge and the staff team identified a change in a resident's behaviour. This recommended an update to the residents intimate care plan. This was completed promptly and it included consultation with the resident's occupational therapist. It was available for review at the centre on the day of inspection.
- A second behaviour support plan was updated on 13 November 2024. Clear guidance was provided for staff to follow. The inspector found that recommendations relating to breakfasting arrangements and organisation of clothing were put in place at that time and reported to work well.
- There was one restrictive practices used and this had a protocol in place. It was the least restrictive procedure and used for the shortest duration necessary. Good documentation was maintained.

While not all staff training was in date, this is reported on under Regulation 15:

Training and staff development.

Judgment: Compliant

Regulation 8: Protection

The provider identified a number of safeguarding concerns in March 2024 which related to compatibility of residents. These were notified to the Chief Inspector of Social Services as outlined under Regulation 31.

- A review of safeguarding arrangements was completed in order to ensure that the provider acted in line with the assurances that they provided at that time and the current safeguarding arrangements were effective.
- The provider had a safeguarding policy and staff training was up-to-date. All staff spoken with knew what to do if a concern arose and most were aware of the identity of the designated officer.
- A review of safeguarding plans found that they were completed in line with the provider's guidance. Where there were grounds for concern, safeguarding plans were in place. Actions included the provision of additional staffing and support and monitoring of interpersonal interactions. In addition, the inspector found that safeguarding requirements were linked to risk assessments and to positive behaviour support plans if required.
- Overall, as the needs of residents living at this centre were changing, the inspector found that there was a reduction in concerns arising relating to compatibility and where they did arise, that they were managed effectively

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Thornvilla Community Group Home OSV-0001936

Inspection ID: MON-0044462

Date of inspection: 05/02/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There is a regular and familiar agency staff nurse working in the designated centre from 22/10/2024 who is knowledgeable in relation to the health needs of all residents. This staff nurse works up to 28 hours within the centre weekly. • This staff nurse provides clinical input/supports where required to service users. • This nurse is involved in developing protocols and guidelines to support workers in the designated centre. • A buddy system has been established with identified CNM2/PIC's to offer guidance and support to PIC. • The HSE's tissue viability nurse liaises with the PIC in developing SSkin bundles where applicable to service users and offers guidance in completing sskin bundle assessments. • There is support and guidance from the clinical nurse specialist in Brain health and CNS in Behaviours of concern to offer support and guidance to staff in relation to behaviours of concern, positive behavioural support and brain health. • There is an on call arrangement in place to support staff and offer clinical guidance from 5 pm every day until 8 am each morning. • All support staff are trained in the Safe Administration of Medications and follow all Policies, procedures, protocols and guidelines in place. • An expression of interest for the 2.5 WTE staff nurse post was circulated by HR in September 2024 and reposted in February 2025. • The service is currently running an additional Staff Nurse Recruitment campaign. This will be completed by 31/05/25. • A risk assessment has been developed in relation to the 2.5 S/N vacancies within the service and documents the current controls in place to mitigate the risks	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The CH CDLMS Disability Services training matrix is in place to record and monitor compliance with mandatory and site-specific training.	

• A Training Needs Analysis is completed annually, which identifies the mandatory and site-specific training requirements for the designated centre. • There was a plan in place for staff to complete site specific training as identified in this report. • All staff have now completed outstanding HSEland training and this has been updated and reflected on the training matrix. • A training compliance report is completed quarterly by the CNM3 in Quality, Risk and Service User Safety and any deficits in training is escalated through senior management • One staff member who requires refresher training in Studio 3 Training has been scheduled for March 2025. This will be completed on 24/03/2025 • A number of staff members who require refresher training in relation to infection prevention and control and health and safety, have been completed post inspection. This was completed on 18/02/2025

Regulation 17: Premises	Substantially Compliant

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

• One resident was referred to the DSMAT for alternative accommodation due to a decline in their health and wellness in January 2025. This resident has now transitioned into alternative suitable accommodation. The transition was completed in conjunction with the wider Multi Discipilinary Team and there was a transition plan in place to support the resident.
• A saddle board requires repair and this will be completed in March 2025 by the maintenance Department. This will be completed on 18/03/2025
• There is a maintenance plan in place to complete the upgrade works to the ground floor bathroom. This action is on the centres QIP and monitored requlary. A completion date of the 14/04/2025 for these works has been agreed with the maintenance departtment.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• The updgrade of fire safety equipment identified by the provider inclusive of ordering and commissioning of a new fire panel, and replacement of all fire doors will be completed by the 30/04/2025. This is on the centers quality improvement plan and is monitored regularly.
• One residents PEEP and the centers CEEP were reviewed on the 05/02/2025 to reflect the supports one resident requires to evacuate the building in the event of an emergency.
• Going forward the Peeps and the centres Ceep will be reviewed should residents needs change.

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 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	31/05/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	24/03/2025
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	Substantially Compliant	Yellow	03/03/2025

	number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	15/04/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/04/2025