Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Disabilities (Mixed).

## Issued by the Chief Inspector

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| Name of designated centre: | Riverwalk Respite House |
| Name of provider: | Health Service Executive |
| Address of centre: | Donegal |
| Type of inspection: | Unannounced |
| Date of inspection: | 24 August 2022 |
| Centre ID: | OSV-0002501 |
| Fieldwork ID: | MON-0032585 |

## About the designated centre

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

Riverwalk House comprises of a one-storey building located in Donegal on the outskirts of a town, but within close proximity to local amenities such as shops and restaurants. The centre provides accommodation for up to three residents. The centre was established as a respite service to provide both day and overnight residential respite care to both children and adults with a disability, with children and adults availing of the centre at separate times. In recent years, the centre has provided full-time care to two residents. In addition to their own bedrooms, residents have access to communal facilities which includes a kitchen-diner, two sitting rooms, a laundry room and bathroom facilities. Residents are supported by a team of both nursing and care staff. Residents are supported with their needs by up to three staff during the day. At night-time, residents' needs are met by two staff.

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

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| 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 |
|---|---|---|---|
| Wednesday 24 August 2022 | 09:45hrs to 16:40hrs | Alanna Ní Mhíocháin | 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 of Social Services undertook a review of all HSE centres in that county. This included a targeted inspection programme which took place over two weeks in January 2022 and focused on Regulation 7: Positive behaviour support, Regulation 8: Protection and Regulation 23: Governance and Management. The overview report of this review has been published on the Health Information and Quality Authority (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 have now commenced a programme of inspections to verify whether these actions have been implemented as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Donegal.

This centre consisted of a bungalow on a campus with other buildings on the edge of a town. On the day of inspection, the centre provided a fulltime service to two residents and was not offering respite services. The person in charge reported that efforts were underway to identify alternative accommodation for the residents. When this accommodation was sourced, it was intended that the respite services in the centre would recommence.

Each resident had their own bedroom in this centre. They also had their own sitting-dining room. They had shared access to the kitchen and bathrooms. The residents' individual rooms had been personalised with their own photographs, belongings and artwork. Each sitting room had a television and comfortable furniture. One sitting room was equipped with sensory lighting and equipment. There was internet access available for residents in the centre. The bedrooms had profiling beds and one had a tracking hoist in the ceiling. In one resident's bedroom, pictures had been added to wardrobe doors and drawers to support the resident when they were putting away their laundry. The bathrooms had level-access showers. There were also shower trolleys, shower chairs and a bath for residents with limited mobility.

While the centre was clean, homely and personalised with the residents' belongings, it required some repair and refurbishment. The flooring in certain parts of the house was damaged and uneven. Paint on the walls was chipped in places and the doors of the cabinets in the utility room were damaged. The person in charge reported that this had been identified and that extensive renovation works to the plumbing and flooring in the house was due to commence on 5 September 2022. Some of the furniture in the centre required repair. The person in charge reported that some furniture was due to be recovered and it was temporarily stored in a spare bedroom in the centre until that was complete. The centre was also due to be repainted

following the installation of the new floors.

Outside, residents had access to the grounds of the campus. One resident had a particular interest in gardening and they had planted flower beds and potted plants around the centre making for a very pleasant display of colour. There were walkways around the centre and the person in charge reported that there were planned refurbishment works for this area also. Hedge trimming and tidying of the walkways had recently been completed. Quotes had been obtained for a new garden shed, new wheelchair accessible picnic tables, a new bench for sitting out, and repairs to a water feature. A handrail was also due to be repaired. Hens were kept in a hen house beside the centre.

The inspector had the opportunity to meet with both residents in the afternoon. Both residents reported that they were happy in the centre. They talked about their own bedrooms and that they were going to be moving to new houses in the future. One resident talked about picking the furnishings and the decor for their new house. They talked about the activities that they enjoyed and some upcoming plans for outings. One resident spoke about visits with family and friends. Residents showed the inspector the projects that they had undertaken in the centre. This included artwork and gardening projects. Residents were observed relaxing in their sitting rooms. One resident was observed completing their gardening projects and going to the hen house to care for the hens, something they said they really enjoyed.

Staff were noted interacting with residents in a friendly and caring manner. They were very respectful of the residents when they spoke about them and knowledgeable on their needs and preferences. Staff were knowledgeable on the residents' communication style and supported the residents to chat with the inspector. Staff offered choices to residents and these choices were respected. They were very responsive when residents asked for assistance. They were knowledgeable on the supports that residents needed to help manage their behaviour and were observed implementing some of the strategies outlined in behaviour support plans. This will be discussed later in the report.

Overall, the inspector found that the service in this centre was of a good quality and that residents' choices were respected. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

## Capacity and capability

As outlined above, the provider had submitted a compliance plan in response to the findings from the targeted inspections in January 2022. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in the centre. This included the introduction of regular meetings within the centre and across the service in the county. The person in charge gave

information on the commencement of these scheduled meetings.

Within the centre, staff meetings occurred on a bi-monthly basis. The most recent meeting had taken place the day before the inspection. All staff were invited to the meeting and minutes of the meetings were made available for staff. The person in charge reported that they had met with the Assistant Director of Nursing in the area on two occasions. The person in this role had left the post and a new person was due to be appointed soon. Therefore, there were no further dates scheduled for these meetings on the day of inspection. The person in charge reported that they could contact the Disability Services Manager if they had any concerns that needed to be escalated until the role of Assistant Director of Nursing was replaced.

On a network level, the person in charge reported that there had been a network quality safety service improvement meeting on 27 April 2022 and that the next one was due to take place on 1 September 2022. The person in charge also reported that one safeguarding review meeting had occurred, but that they had not been able to attend the meetings. They were unaware of dates for any future planned meetings.

On a county-wide level, meetings between all of the persons in charge of designated centres in the county occurred on a fortnightly basis. The person in charge reported that these meetings were beneficial for shared learning between centres. The person in charge reported that the shared learning covered a broad range of areas and that colleagues could give advice on issues that they had encountered previously in their service. The meetings also offered opportunities for networking and the person in charge reported that they would now know which of their colleagues to contact if they needed guidance on a particular matter. The meetings were chaired by a member of senior management and any relevant issues discussed at senior management meetings were communicated to persons in charge at this meeting. Minutes from some senior management meetings were available in the centre, for example, the human rights committee meeting.

The provider had also committed to reviewing the audits that were in use in designated centres in the county. On the day of inspection, this review had been completed and new audit tools and a new audit schedule had been issued to the centre. The person in charge reported that the new audit tools would be in use from 1 September 2022.

The inspector reviewed the existing audits in the centre. These audits were completed routinely and findings from audits were added to the centre's quality improvement plan. This plan outlined specific actions that needed to be completed to address issues found on audit within a certain timeframe. The provider's most recent annual review and six-monthly unannounced audit into the quality and safety of care and support in the centre were reviewed. These reports outlined specific quality improvement actions with timeframes for completion. These were also added to the centre's quality improvement plan. The quality improvement plan was reviewed monthly. It was noted that most actions were completed within the target timeframe. However, there were a number of actions relating to staff training that had not been completed by their target date. This was reflected in the staff training

records.

The provider had identified 32 mandatory training modules for all staff and 13 additional modules that were specific to the staff working in this centre. It was noted that all staff were fully up to date in some modules, for example, fire training and safeguarding. However, a number of staff required training in some modules. For example, five staff needed training in primary food hygiene, four in standard precautions and four in cardiopulmonary resuscitation. The person in charge reported that they had requested training dates for some of these modules but no confirmed dates had been scheduled on the day of inspection.

Staffing arrangements in the centre were reviewed. The person in charge maintained a planned and actual staff roster. It was noted that the person in charge was required to fill the role of staff nurse in the centre on a number of occasions in the weeks prior to the inspection to facilitate annual leave. This was as a result of vacant nursing posts in the centre. This meant that the role of person in charge was not always supernumerary and as a result, impacted on their ability to complete their role.

Overall, there was good oversight of this service and clear lines of escalation and accountability. Issues identified on audit were addressed to ensure a quality service. However, some improvement was required in order to ensure that all actions were completed in line with targets set by the provider. Some improvement was also needed in staff training and staffing arrangements.

## Regulation 15: Staffing

There was a planned and actual staff roster in the centre. This indicated that the required number of staff and necessary skill-mix was available in the centre as required. However, due to a number of nursing vacancies and the lack of availability of agency nursing staff, the person in charge had been required to fulfil the role of staff nurse to facilitate annual leave. This impacted on the continuity of care for residents.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

The provider had identified a number of training modules for staff in this centre and facilitated access to training. However, some staff had not completed all training modules. For example, five staff needed training in primary food hygiene.

Judgment: Substantially compliant

## Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance 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.

At the time of inspection, all ten actions relating to the governance meetings were complete. The governance meetings had been established and information was shared from senior management meetings at the fortnightly meetings between persons in charge. The person in charge spoke of the benefits of this meeting for shared learning between centres.

The planned audit review had occurred. A new suite of audit tools and a schedule for their use throughout the year was available. The new schedule outlined if audits should be completed more frequently depending on the audit score. There was also scope in the audit schedule to include audit tools specific to the centre or service. However, this schedule had not yet been implemented and was due to commence on 1 September 2022. Therefore, the effectiveness of the new audit tools and schedule had yet to be established.

Audits in this centre were completed routinely and identified improvements were added to a quality improvement plan. There was evidence that most actions were completed in line with the targets set by the provider. However, certain actions in the quality improvement plan had not been completed in line with the targets set by the provider. The provider had completed annual reviews and six-monthly unannounced audits in line with the regulations. There were clear lines of accountability and management structures in this centre.

Judgment: Substantially compliant

## Quality and safety

The inspector found that residents in this centre were in receipt of a good quality service. They were supported to engage in activities that were in line with their interests. Residents' rights were upheld in the centre and their independence was promoted by staff who were very knowledgeable of the needs of residents. Some improvement was required in relation to documentation regarding behaviour support plans and not all risks had been fully assessed.

The inspector reviewed a sample of residents' assessments and personal plans. Residents' health, social and personal needs were assessed within the previous 12 months. Where a need had been identified, a care plan had been devised to guide staff on how best to support residents with those needs. The care plans were regularly reviewed with detailed updates on the residents' needs. Residents' personal plans also outlined goals that they wanted to achieve in the coming year. There was evidence that these goals were regularly reviewed and updated with the residents' progress. Residents' personal plans contained photographs of residents undertaking activities in line with these goals. Residents' personal plans were reviewed annually. This review included the residents and members of the multidisciplinary team. The effectiveness of the plan was reviewed and goals for the coming year were identified. There was evidence of good management of residents' healthcare needs in the personal plans. A detailed medical history was kept for all residents and there was evidence of follow-up with medical appointments. Residents were referred to various healthcare professionals, as required. This included referrals to dietitians and speech and language therapists in relation to residents' nutritional needs. Staff were knowledgeable on the recommendations made by these professionals and how to support residents with their nutritional needs.

Where required, residents' personal plans contained behaviour support plans. These had been devised by relevant health professionals and were up to date. The plans gave guidance to staff on how to support residents to remain calm and how to support them if they became upset or anxious. In conversation with the inspector, staff were knowledgeable on the content of the plans. During the inspection, the inspector observed staff using some of the techniques outlined in the plan to good effect. Where medication was needed to support residents manage their behaviour, there was a clear protocol that outlined the dose of medication that should be given and the criteria that would warrant its administration. The person in charge reported that this protocol had been reviewed on a number of occasions to ensure that it gave clear guidance to staff. Staff were knowledgeable on when the medication could be administered.

Positive behaviour support was also part of the provider's compliance plan. This outlined that a training needs analysis would be completed in each area with a corresponding training schedule. The person in charge reported that training records were maintained, but that an analysis of the training needs of staff in this centre had not been completed. Staff training was included as an agenda item on staff meetings in the centre and at the meetings between persons in charge. The compliance plan stated that staff would be required to sign-off on any behaviour support plans. However, on the day of inspection, this had not occurred in this centre. The compliance plan also outlined that the induction packs in centres would be reviewed. The inspector reviewed the standard induction pack that was used in the centre. This outlined broad information about working within the service but there was no site-specific induction pack or programme in place for this centre. Induction packs and information sheets had not been updated since 27 March 2020.

The provider had also commenced a number of the actions relating to safeguarding that were identified in the compliance plan submitted following the targeted inspections in January 2022. The person in charge reported that safeguarding logs

were maintained in the centre and were reviewed monthly. There was also a weekly cross-referencing of incidents and safeguarding plans completed by the safeguarding team. The person in charge had completed training in incident management and safeguarding, including training on preliminary screening and safeguarding plans. All staff in the centre, except one, had completed training in Sexuality Awareness in Supported Settings (SASS). There were plans for the person in charge and a staff nurse in the centre to complete training to become designated officers. The policy on safe Wi-Fi usage was in development. However, in the interim, there was no risk assessment in the centre in relation to safe internet access for residents. There were no open safeguarding plans in the centre on the day of inspection. All staff were trained in safeguarding. Residents had detailed intimate care plans that outlined specific supports that they required.

Residents' rights were respected and promoted in this centre. Staff were observed offering choices to residents and these choices were respected. There were weekly resident meetings where residents could be included in the running of the centre. Residents' independence was promoted and supported. For example, picture supports were in place to assist residents complete personal care tasks and household chores independently. Staff were very familiar with the residents' communication style that ensured that residents could express their needs and preferences. Staff were easily able to converse with residents and supported residents to chat with the inspector. Communication dictionaries were kept in residents' personal plans that explained the meaning of residents' gestures, specific phrases, and their non-verbal behaviour. Residents were supported to choose and participate in activities and events that were in line with their interests. This included personal tasks like shopping and running errands. It also included social events and hobbies, for example, attending open days, bowling, eating out, visiting farms, beauty treatments and meeting friends.

The arrangements for the assessment and management of risk in the centre was reviewed. The person in charge maintained a risk register in the centre. This was comprehensive and accurately identified risks to residents, staff, visitors and the service as a whole. Control measures to reduce the risks were identified. Risks were regularly reviewed. However, as outlined above, not all risks identified on the day of inspection had been identified. Individual residents had risk assessments in their personal plans that gave guidance to staff on how to reduce specific risks to residents. Again, these gave clear guidance to staff and were regularly reviewed.

Overall, there was a very good service in this centre. Residents' rights were respected and their independence was promoted. They were supported to engage in activities that they enjoyed and that were meaningful. Staff were knowledgeable on the needs of residents and on the specific supports they required.

## Regulation 10: Communication

Residents' communication needs and strength were outlined in their personal plans.

Staff were knowledgeable on the residents' communication style and could easily communicate with residents and support residents to speak with new people. Residents had access to phone, television and internet.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents were supported to engage in a wide range of activities, hobbies and tasks that were in line with their interests. Residents were supported to form links with the wider community. They were also supported to maintain personal relationships with family and friends.

Judgment: Compliant

## Regulation 18: Food and nutrition

There was ample food in the centre for meals, refreshments and snacks. Residents were supported to make choices in relation to their food and meals. They were supported to go grocery shopping if they wished. Their specific needs in relation to nutrition and swallow safety had been assessed and staff were knowledgeable on residents' specific needs in this regard.

Judgment: Compliant

## Regulation 26: Risk management procedures

Individual residents had risk assessments that gave clear guidance to staff on how to manage risks to residents. These were reviewed regularly. A risk register was also maintained for the service as a whole. This was comprehensive and, again, gave clear guidance to staff on how to reduce risks. However, not all risks identified on inspection, specifically in relation to safe use of the internet by residents, had been identified and assessed.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Residents had a comprehensive assessment of their health, personal and social care needs. This assessment was completed within the last 12 months. Where a need was identified, there was a corresponding care plan that guided staff on how to support residents. These plans included goals that were set by the resident. An annual review was completed within the last 12 months that reviewed the effectiveness of the plans and set new goals for the year.

Judgment: Compliant

## Regulation 6: Health care

The resident's healthcare needs were well managed. They had a named general practitioner (GP). There was access to different healthcare professionals as required by the resident. Referrals had been made to specialist healthcare services when needed.

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 six of these actions on the day of inspection; the approval of multidisciplinary supports, three actions relating to staff training and two actions relating to staff induction.

Two of these actions had been completed.

- The inspector found that the multidisciplinary posts were in progress and that persons in charge were informed of the progress regarding these posts.
- Staff training was included as an agenda item in meetings in the centre.

Four actions had not been completed:

- The person in charge reported that they had given feedback on the training needs of staff in the centre. However, a formal training needs analysis in the centre had not taken place.
- There was no staff sign-off sheet for the behaviour support plans in the centre.

- The induction pack used in the centre had not been reviewed and information in the existing pack was not reflective of the service on the day of inspection.
- There was no interim induction checklist in the centre for employees assigned to the centre at short notice.

In the centre, behaviour support plans were in place when required. These had been devised by a relevant healthcare professional. Staff were knowledgeable on the content of the plan and used some of the strategies to good effect on the day of inspection. Restrictive practices in the centre were kept under review to ensure that they were the least restrictive option. This include the use of medication to support residents manage their behaviour.

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 all of the actions on this inspection. Seven of the actions were complete.

- The person in charge had completed incident management and safeguarding training
- The person in charge had received training regarding preliminary screening and safeguarding plans
- A network safeguarding tracking log had been implemented
- Incidents in the centre were cross-referenced against safeguarding plans.
- Training schedules were included as agenda items in the minutes of governance meetings
- The network safeguarding review meetings had commenced.
- The review of the audit schedule and tool pertaining to safeguarding had been completed. A new suite of audit tools and audit schedule had been developed and was due to commence on 1 September 2022.

Five of the actions had commenced but were not yet complete.

- None of the staff in the centre had received training in 'Speakeasy Plus'.
- All staff except one had received training in SASS.
- As outlined previously, a formal training needs analysis had not been completed.
- There were plans for the person in charge and a staff nurse to complete training as designated officers.
- The policy for the provision of safe Wi-Fi usage was in process.

One action had not been completed.

- There was no staff sign-off sheet for behaviour support plans in the centre.

In the centre, there were no open safeguarding plans on the day of inspection. All staff were trained in safeguarding. Residents had intimate care plans that gave clear guidance to staff on the support needed by residents.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

Residents' rights were respected in the centre. Residents were routinely offered choice and these choices were respected. Residents were supported to be active participants in the running of the centre. Their privacy and dignity was respected.

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 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Substantially compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Riverwalk Respite House OSV-0002501

## Inspection ID: MON-0032585

## Date of inspection: 24/08/2022

**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 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>To ensure compliance with Regulation 15: Staffing, the following actions has taken place<br><br>• All Documentation for staffing has been submitted and escalated for approval as position became vacant.<br>• Staff Nurse position has been offered out to the current panel, in the interim vacancy is being filled by familiar, regular agency staff.<br>• Recruitment process is lengthy hence extended date of 02/23 to allow for time for all documentation to be completed and vacant positions filled | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>To ensure compliance with Regulation 16: Training and Staff Development the following actions will be taken.<br><br>• All staff to complete mandatory HSEland training and certs to be submitted to PIC by 30/11/2022<br>• Training matrix to be updated to include site specific training needs 29/10/2022<br>• Practical/face to face training to be booked by PIC, staff to be informed of dates of training and same to be reflected on center off-duty 14/10/2022 | |

| | |
|---|---|
| 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 Regulation 23: Governance and Management the following actions will be taken

• QIP reviewed and update on all outstanding actions have been inputed 29/10/2022
• Actions identified in the QIP had dates reviewed or extended to allow for scope of works to be completed due to inability to source materials
• PIC reviewed training and training needs analysis will be provided to all staff by 29/10/2022
• Pic to ensure that all behavior support plans are read, understood and signed by staff by 31/10/2022
• Pic has reviewed induction packs and developed site-specific induction pack, to be completed by all staff by 30/11/2022

| | |
|---|---|
| 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 Regulation 26: Risk Management Procedures, the following actions has been completed

• Risk assessment on safe use of internet completed on 15/09/2022
• All staff have will have completed SASS training by 12/10/2022

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|---|---|
| Regulation 7: Positive behavioural support | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To ensure compliance with Regulation 7: Behavioural Support, the following actions will

be taken

• BSP & attached sign sheet in circulation for staff attention to be completed by 31/10/2022
• Site orientation induction checklist in place within the centre 29/10/2022
• PIC will review induction pack and ensure information contained within is reflective of services provided within the centre 29/10/2022

| | |
|---|---|
| Regulation 8: Protection | Substantially Compliant |

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

• Training Matrix has been updated to include site specific training 29/10/2022
• PIC will ensure staff have been given individual training needs analysis 31/10/2022
• The development of the WIFI policy is ongoing however the Digital Health lead held an information session with the PIC's and identified strategies that are in progress to ensure the use of online equipment safety for Service users.
• 1 Staff member to complete SASS training on 12/10/2022

## Section 2:

## Regulations to be complied with

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

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

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 15(1) | The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. | Substantially Compliant | Yellow | 28/02/2023 |
| 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 | 30/11/2022 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in | Substantially Compliant | Yellow | 30/09/2022 |

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| | place in the designated centre to ensure that the 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. | Substantially Compliant | Yellow | 15/09/2022 |
| 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. | Substantially Compliant | Yellow | 30/09/2022 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 30/09/2022 |