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

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| Name of designated centre: | James Connolly Memorial Residential Unit |
| Name of provider: | Health Service Executive |
| Address of centre: | Donegal |
| Type of inspection: | Unannounced |
| Date of inspection: | 17 April 2023 and 18 April 2023 |
| Centre ID: | OSV-0002502 |
| Fieldwork ID: | MON-0039233 |

## About the designated centre

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

James Connolly Memorial Residential Unit is a congregated setting providing care and support to 9 adults with disabilities (both male and female) in Co. Donegal. The premises consist of a large two storey building and is institutional in design. Communal facilities include two large sleeping dormitories (one female and one male). There are also single occupancy bedrooms. All bedroom facilities are on the ground floor of the centre. A large bright sitting/TV room, multiple bathroom/restroom facilities, a relaxation/sensory area, dining rooms and a small kitchenette which is available for residents to use are also located on the ground floor. There is also a larger industrial-style kitchen on the ground floor (not accessible to the residents) that provides meals at specific times throughout the day to residents. The second floor has facilities for management and staff of the centre including offices, a kitchen, a staff dining area and staff restroom. The centre is located on a site from which a range of other Health Service Executive (HSE) services are accommodated. The building is surrounded by gardens and grounds that are well-maintained and private parking facilities are available. The centre is staffed on a 24/7 basis with a full time person in charge (who is a clinical nurse manager II), a team of staff nurses and health care assistants. Access to GP services and other allied healthcare professionals form part of the service provided to the residents. Transport is also provided for residents for residents use.

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

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| Number of residents on the date of inspection: | 9 |

## 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 |
|---|---|---|---|
| Monday 17 April 2023 | 14:15hrs to 18:30hrs | Úna McDermott | Lead |
| Tuesday 18 April 2023 | 09:00hrs to 12:30hrs | Úna McDermott | Lead |
| Monday 17 April 2023 | 14:15hrs to 18:30hrs | Mary McCann | Support |
| Tuesday 18 April 2023 | 09:00hrs to 12:30hrs | Mary McCann | Support |

## What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. It was a follow up to an inspection that took place in December 2022. At that time, inspectors inspected twelve regulations and found seven were not compliant and three regulations were substantially compliant and two were compliant. At this time, there were concerns in relation to the welfare of the residents and the safety of the service provided. In response to these findings, the provider submitted a compliance plan which detailed the actions that they planned to take in order to bring this centre into compliance

The purpose of this inspection was to assess the provider's capacity and capability to sustain their ongoing response to the actions required in order to return to full compliance. From what the inspectors observed during this this inspection, improvements were apparent. The governance team were settling into their roles and there were improvements in the resident's quality of life and the safety of the service provided.

This centre is a congregated setting and institutional in design. It is a large two-storey building with residents' living quarters on the ground floor and a staff kitchenette, dining room and administrative offices upstairs. The living quarters comprised of two communal sleeping dormitories, one male and one female, and four single occupancy bedrooms. Inspectors found that there was a reduction in the number of shared sleeping spaces and this will expanded on under regulation 17 below. Facilities for bathing and showering were provided. There was a large dining room and a kitchen where a professional catering service was provided. There was a kitchenette and dining area next door for residents to use. This kitchenette was locked at the time of the last inspection but, on this inspection it was unlocked and available for residents use as required. Towards the front of the building there was a large sitting area. There was an activity room and a multi-sensory room close by. The activity room was well-equipped and inspectors noted additional equipment was purchased for use in both of these rooms since the last inspection. The door from the activity room was open and access to a small paved area was provided. Garden seating and raised flower beds were available for residents use. This area was in a good location and was accessible for resident's needs. However, it was noted to require repair and this will be expanded on later in this report. Overall, the inspectors found that staff continued to make concerted efforts to enhance the centre in order to promote a homely atmosphere. However, staff acknowledged this to be challenging due to the age and layout of the premises provided.

There were nine residents living at this designated centre. The residents did not communicate verbally with the inspectors, however they engaged non-verbally when spoken with. The staff on duty told the inspectors that the day service remained closed and that residents participated in centre based and community based activities. On the first day of inspection, two residents were out on a day trip to a local airport as they had an interest in aeroplanes. Others went bowling and, as it

was a good day, some residents spent time in the garden. An activities co-ordinator was employed on week-days and they were observed supporting residents with activities of their choice. Interactions between the co-ordinator and the residents were observed to be kind and respectful.

Later that afternoon, inspectors spent time in the dining room where the evening meal was being served. On the day of inspection, this meal was served at 4pm. The staff on duty told the inspectors that since the previous inspection, staff had additional training in food safety. This meant that some meals could be prepared by the trained staff at a later time. In addition, inspectors found that there was improvement in the choice of evening snacks provided.

As outlined above, inspectors found improvements in the quality and safety of the service provided. In addition, it was evident that discussions were taking place with the staff team in order to acknowledge and change remaining institutional routines taking place. Staff spoken with told the inspectors that they had attending training in a human rights based approach and that this had a positive impact on their work. In addition, residents had access to advocacy services in relation to the plan to move to new homes in their communities. However, further improvements in regulatory compliance is required which will be expanded on throughout this report.

The next two sections present the findings 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 the residents.

## Capacity and capability

A change in the leadership and management arrangements in this centre took place in autumn 2022 and further changes had taken place since that time. This meant that the person in charge, an acting assistant director of nursing and an acting disability service manager were in post. In addition, the clinical nurse manager 3 had returned to their role in the service. Inspectors found that the governance team were adjusting to their roles, however, they had management systems in place to monitor the provision of the service provided. These systems and processes were noted to have improved since the last inspection. Further review was required in relation to staffing, training and development, positive behaviour support, residents' rights, risk, premises and overall governance and management was required in order to further enhance the quality and safety of the service provided.

The registration of this designated centre has a restrictive condition attached. This means that the provider is required to move the residents to more appropriate living arrangements by 31st December 2023. Therefore, the purpose of this inspection was to monitor the provider's capacity and capability to meet this deadline and to make and sustain improvements based on the findings of the December 2022

inspection.

On arrival at the centre, the inspectors met with the person in charge. The acting disability manager and the acting assistant director of nursing attended later. The person had responsibility for this designated centre only and their role was supported by the clinical nurse manager . The staff team consisted of nurses, healthcare assistants and an activities co-ordinator. The person in charge told the inspectors that there were 28 core staff members employed to provide care and support to residents. In addition to this, they had managerial oversight for 10 non-core staff members who worked in supporting roles.

Under Regulation 15, the staff roster was reviewed and in the main, it was found to provide an accurate reflection of the staff on duty on the day of inspection. In addition, arrangements were in place to provide consistency of care and support. On review of the staff rota inspectors noted not all leave arrangements were adequately documented. This was reviewed by the provider representative on the day of inspection and amended in order to provide an accurate reflection of the staff on duty. In addition, a review of staff resources since the last inspection was completed. This found that an additional 7.5 whole time equivalent staff members were employed which comprised of 3 nurses and 4.5 healthcare assistants. The person in charge stated that this meant that two staff nurses would be on duty during daytime hours. However, on the day of inspection and over a sample of days reviewed on the same week, there was one nurse on duty only.

Staff employed had access to training and development as part of a continuous professional development programme. A training matrix was in place and fire training was taking place on the day of inspection. Additional training in the management of epilepsy for healthcare assistants and food hygiene was provided since the last inspection. This meant that residents had increased opportunities to access community activities. In addition and as outlined above, staff had attended training in human rights training. However, a review of the training records found that not all training modules were up to date. These included modules on health and safety, moving and handling, infection prevention and control, restrictive practices and positive behaviour support. The provider representative and the person in charge told the inspectors that they had a plan in place to ensure that staff could be released to attend training. In addition, a new staff member was a moving and handling trainer and they told the inspectors that they could assist with training if required.

A review of policies and procedures as required under Schedule 5 of the regulations was completed. This was a follow up to the actions agreed with the provider post the June and December 2022 inspections. The inspectors found that all policies from the sample viewed were up to date and an audit was completed on a monthly basis.

A clearly defined management structure was in place which, as outlined, had changed recently. The clinical nurse manager was reinstated since February 2023 and this was reported to work well. The provider representative told the inspectors that a staffing skill mix review was ongoing. Evidence of meetings and discussion was provided to support this work. As previously outlined in this report, although the

number of staff employed had increased , ongoing work was required to ensure that annual leave requests were covered without impact on the number of nursing staff on duty on a day to day basis.

A review of the governance and management systems and processes in place found improvements. Information in the form of policies, procedures and protocols was available. Residents' files were well organised in a way that information was clear, relevant to residents' current needs and easily accessible. This was an action from the last inspection. A 'named nurse' and 'keyworker' system was in place and this was reported to work well.

A review of the auditing systems used found that the annual review of quality and safety of care was completed. The provider-led six monthly audit was completed in December 2022. A quality improvement plan was in place and this was reviewed recently. As outlined at the previous inspection this included an action in relation to the resumption of day services and an associated risk assessment. This action was open for a significant amount of time and as changes had occurred in the service since this time; it required review.

Work in relation to the recommendations of allied health professionals such as speech and language therapy was ongoing, however, improvements were noted. For example, 'objects of reference' were in use by the staff on duty and a plan was in place for additional training to be provided.

A review of monitoring notifications submitted to the Chief Inspector found that they were provided in accordance with the requirements of the regulation.

The next section of this report describes the care and support that people receive and if it was of good quality and ensured that people were safe.

## Regulation 15: Staffing

The provider had some staffing arrangements in place in order to meet the assessed needs of the residents. Continuity of care and support was provided and on-call arrangements were in place. However, the following required review;

- to ensure that the roster provides an accurate description of the staff on duty and that it is properly maintained.
- to ensure that the staffing levels meet the assessed needs of residents and protect their care and welfare at all times.

Judgment: Not compliant

## Regulation 16: Training and staff development

Staff had access to training, including refresher training as part of a continuous professional development programme. Formal supervision was provided. The following required review;

- to ensure that all training is up to date for staff. This included modules on health and safety, moving and handling, infection prevention and control, restrictive practices and positive behaviour support.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The provider had management structures and systems in place. A system of audits were used to monitor the quality and safety of the service provided. The annual report and the six-monthly provider led audit were up to date. A quality improvement plan was in place. The following areas required review;

- to ensure that staffing positions, including those relating to governance and management are secure, consistent and appropriate for the assessed needs of the residents
- to ensure that all training modules are up to date
- to ensure that all risk assessments are reviewed regularly

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The person in charge ensured that monitoring notifications were reported to the Chief Inspector in a timely manner and in accordance with the requirements of the regulation.

Judgment: Compliant

## Regulation 4: Written policies and procedures

The provider had policies and procedures and guidelines which met with the requirements of Schedule 5 of the regulation.

Judgment: Compliant

## Quality and safety

Resident's welfare was supported by a good standard of care and support provided. As outlined previously, improvements were noted since the last inspection. However, further improvement was required in the areas of staffing, training and development, positive behaviour support, residents' rights, risk, premises and overall governance and management which would further enhance the quality and safety of the service provided.

A resident that required support with behaviours of concern had a positive behaviour support plan in place which was developed with the support of a psychologist. At the time of inspection, the provider representative told the inspectors that a behaviour therapist or a clinical nurse specialist was not available in their area, however the support of a psychologist was in place. Most staff had training in positive behaviour support and one staff member was due to complete this training. Restrictive practices were in use in this centre and the policy was up to date. As part of the compliance plan submitted, the provided had an action in relation to training on restrictive practices and on what constitutes a restrictive practice. There was no evidence of a specific training event in relation to this. However, a review of the restrictive practice register showed that there was a reduction in the amount of restrictions used since the last inspection. This included the removal of the lock on the kitchenette provided for residents use. In addition, where a restriction was in use, it was supported by the use of protocol which provided a rationale.

The provider had systems in place to ensure that residents were protected from abuse. This included an up-to-date safeguarding policy and the provision of staff training in safeguarding and protection. Where an incident occurred it was acted on in line with the provider's policy and in line with national guidelines. Evidence of a post safeguarding incident review was provided. Furthermore, safeguarding and protection was discussed at staff meetings, the identity of the designated officer was clearly displayed and staff were aware of what to do if required.

Inspectors found some improvements in relation to the arrangements in place to ensure that residents' rights were respected. As previously outlined, staff had access to human rights training and a psychologist had facilitated a human rights meeting. Two residents had the support of an advocate. At county level, there was evidence of human rights meetings which were attended by the person in charge. However, inspectors found that further improvements were required to achieve compliance. This related to practices such as the use of staff personal alarm system. Staff told the inspectors that the alarm was used if a resident had a seizure and if nursing support was required. Inspectors found that when activated, it would ring loudly throughout the building without consideration for privacy and discretion. This required review. In addition, although improvements in the timing of meals provided

were reported, on the day of inspection, the final meal of the evening was served at 4pm. This required ongoing review.

Residents living at this centre had a range of centre and community based activities provided and an activities co-ordinator was in place. On the day of inspection, residents were observed participating in a range of activities both in their home and in their community. Inspectors found that access to facilities for occupation and recreation were provided and these were reviewed regularly. For example, one resident had started to attend a singing group which was held locally and they were reported to enjoy this very much. Others were attending outings in their community and in addition, a range of centre based activities were taking place.

The provider had systems in place for the assessment, management and review of risk. The risk management policy was up to date. Service level risk assessments were in place and in addition, residents had person-centred risk assessments which were subject to regular review. However, a risk assessment in relation to the provision of day services which was dated 2020 required review. This was because some time had passed since this risk was identified. Therefore, the risk assessment did not reflect the current situation. For example, there were less residents living at the centre, additional staff were in place and these staff had enhanced training which ensured that they could support residents in their communities. This meant that there was an increased range of activities taking place which were reported to meet with the assessed needs of the residents. This assessment required review to ensure that it was relevant to the assessed needs and preferences of residents living at the centre at this time.

A walk around of the premises found a reduction in the number of multi-occupancy dormitories since the previous inspection, as three residents had moved into single occupancy rooms. This meant that there was better utilisation of the rooms provided to ensure improved respect for the privacy and dignity of the residents living at this centre. However, as previously outlined, this designated centre was located in an institutional setting and until de-congregation occurs, a number of residents will continue to be accommodated multi-occupancy dormitories and to live in an institutional premises. In addition, inspectors found that improvements were required with the garden space provided in order to provider residents with enhanced areas to enjoy during the summer months.

In summary, inspectors found improvements in the leadership and management arrangements in place since the last inspection and this had an impact on the quality and safety of the service provided. However, further improvement was required in the areas of staffing, human rights, premises, training and development, positive behaviour support, risk management, and overall governance and management which would further enhance the quality and safety of the service provided.

## Regulation 13: General welfare and development

The provider ensured that residents living at this centre had access to a range of

centre and community based activities which were in line with their preferences and assessed needs.

Judgment: Compliant

## Regulation 17: Premises

A de-congregation plan was in progress for this designated centre. However, the inspectors found that the design of the premises remained unsuitable for the needs of the residents.

Judgment: Not compliant

## Regulation 26: Risk management procedures

There provider had systems in place for the assessment, management and ongoing review of risk. The following areas required review;

- to ensure that risks identified were reviewed in order to ensure that they were up to date.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

A resident that required support with behaviours of concern had a positive behaviour support plan available. The following required improvement;

- to ensure that training in positive behaviour support and restrictive practices is provided for all staff who provide direct care to residents
- to ensure that restrictive practices are on the agenda for all team meetings.

Judgment: Substantially compliant

## Regulation 8: Protection

The provider had systems in place to ensure that residents were protected from abuse. This included an up-to-date safeguarding policy and the provision of staff

training in safeguarding and protection. Where an incident occurred it was acted on in line with the provider's policy and in line with national guidelines.

Judgment: Compliant

## Regulation 9: Residents' rights

The provider had made improvements in relation to the human rights of residents living at this designated centre. However, the following arrangements required review;

- the use of personal alarms
- mealtimes in place including the timing of the evening meal
- the use of multi-occupancy dormitories

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 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 4: Written policies and procedures | Compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for James Connolly Memorial Residential Unit OSV-0002502

## Inspection ID: MON-0039233

## Date of inspection: 17/04/2023 and 18/04/2023

**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 | Not 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 have been undertaken;<br><br>• The Person in Charge has completed a review of the staff Rota and staffing requirements .This review is to ensure the effective delivery of care and support for the residents in line with the centres Statement of Purpose – Date of completion 15/05/23<br>• The Person in Charge will ensure that the Rota provides an accurate description of the staff on duty and this will be appropriately maintained. | |
| 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>• The Person in Charge has reviewed the centres training matrix completed 18/04/2023.<br><br>• A training plan has been provided for each member of staff who will have completed all mandatory HSELand training and present certificates for updating of the training matrix by 31/05/2023.<br>• A further Human Rights Training programme has been scheduled for 30/05/2023 for all nursing staff and care staff | |

• Schedules are in place for all other required face to face training to be completed by 10th June 2023.

| Regulation 23: Governance and management | Substantially Compliant |
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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

• A system has been agreed for all documentation for staffing vacancies to be submitted and escalated for approval as position became vacant.

• One Staff Nurse position has been offered out to the current panel, in the interim this vacancy is being filled by familiar staff and the existing nursing staffing compliment working within the centre.

• All Form B's have been completed and submitted for the current vacant positions.

• A training plan has been provided for each member of staff who will have completed all mandatory HSEland training and present certificates for updating of the training matrix by 31/05/2023. A weekly audit off the training matrix will take place on Mondays, to ensure the outstanding training is progressing.
• The Person in Charge is currently reviewing all risk assessments within the centre to ensure they accurately reflect the centres current status and are rated appropriately.
Date off completion 30/05/2023

| Regulation 17: Premises | Not Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance with Regulation 17: Premises, the following actions has taken place

• A decongregation plan has been developed for this centre which is due to be completed by 31/12/23. An update has been submitted to the regulator on 25/01/23 – Date for completion 31/12/23

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| • The premises will be kept under constant review. The outside garden area is currently having work completed to enable residents to utilize the outside gardens in the summer months. Date for completion 30/05/2023 |

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| Regulation 26: Risk management procedures | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>To ensure compliance with Regulation 26: Risk Management Procedures, the following actions has been completed<br><br>The Person in Charge is currently reviewing all risk assessments within the centre to ensure they accurately reflect the centres current status and are rated appropriately. Date off completion 30/05/2023. | |
| Regulation 7: Positive behavioural support | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:<br>To ensure compliance with Regulation 7: Positive Behavioural Support, the following actions will be taken<br><br>• Training in Positive Behavior Support delivered by psychology and Social work (Face to Face) has now been scheduled for all staff. Date for Completion 30/05/2023<br><br>• Human Rights and Restrictive Practices are standing item on agenda at team meetings. | |
| Regulation 9: Residents' rights | Not Compliant |
| Outline how you are going to come into compliance with Regulation 9: Residents' rights:<br>To ensure compliance with Regulation 7: Residents Rights, the following actions will be taken | |

• The Person in Charge has completed a review of the restrictive practices to ensure that they are in line with the national policy in relation to being the least restrictive practice for the shortest duration
• The personal alarms are no longer in use.
• The Person in Charge and catering manager will complete a review of meal times and meal options for residents. Date for completion 30/05/2023

• Dormitory room presently occupied by 2 residents is currently being uncluttered of all equipment. Once uncluttered the room will be decorated and the space divided to ensure additional personal space for residents and their belongings. Date for completion 15/06/2023

## 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. | Not Compliant | Orange | 15/05/2023 |
| 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 | 10/06/2023 |
| 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 | Not Compliant | Orange | 15/06/2023 |

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| | number and needs of residents. | | | |
| Regulation 23(1)(a) | The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. | Substantially Compliant | Yellow | 15/05/2023 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Substantially Compliant | Yellow | 15/05/2023 |
| 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 | 30/05/2023 |
| Regulation 07(2) | The person in charge shall ensure that staff receive training in the management of behaviour that is challenging | Substantially Compliant | Yellow | 10/06/2023 |

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| | including de-escalation and intervention techniques. | | | |
| Regulation 09(1) | The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident. | Not Compliant | Orange | 15/06/2023 |
| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | Not Compliant | Orange | 15/06/2023 |