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:	Abbey Village Group Homes
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	18 May 2022 and 19 May 2022
Centre ID:	OSV-0005250
Fieldwork ID:	MON-0036249

About the designated centre

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

Abbey Village Community Group Homes provides full-time residential care and support to fifteen adults (male and female) with a disability. The designated centre comprises of three, five bedded bungalows. Residents in each bungalow have their own bedrooms and also have access to communal living rooms, kitchen dining rooms and bathroom facilities. The centre is located in a residential housing estate in a rural village and is close to local amenities such as shops and cafes. Residents are supported by a team of nurses and health care assistants, with staffing arrangements in each bungalow being based on residents' assessed needs. Abbey Village Community Group Homes aims to provide residential services where each resident is cared for using person-centred planning in close partnership with the resident, carers and families thus empowering each resident to live life to the full within the community in which they live, encompassing social, emotional, spiritual and financial development and independence.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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 18 May 2022	14:10hrs to 18:30hrs	Angela McCormack	Lead
Thursday 19 May 2022	09:45hrs to 14:30hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This centre is run by the Health Service Executive (HSE) in Community Healthcare Organisation Area 1 (CHO1). Due to concerns about the management of safeguarding concerns and overall governance and oversight of HSE centres in Co. Donegal, the Chief Inspector undertook a review of all HSE centres in that county, including a targeted inspection programme which took place over two weeks in January 2022 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection) and regulation 23 (Governance and management). The overview report of this review has been published on the HIQA website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors 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.

At the time of the inspection the provider had implemented a number of actions to strengthen the governance and management of the centre. These will be discussed in more detail in the other sections of the report.

There were 15 residents living in Abbey Village Group homes at the time of inspection. The inspector got the opportunity to meet with 14 residents over the course of the inspection. Residents interacted with the inspector on their own terms and some residents chose to spend time speaking with the inspector in the company of staff and some residents chose to speak with the inspector alone.

Residents spoken with were happy living in the centre and said that they felt safe. They spoke about activities that they enjoyed. Some residents spoke about a recent country music concert that they attended and there was a photograph of residents meeting with the country music artist. One resident spoke about having been on a recent break away to a hotel in a city and they talked about how they enjoyed this and what they did while there. They said that they were planning their next trip away to another city. One resident spoken with complimented the staff saying that they were very good to them, and they said that they get out and about when they choose to.

Some residents attended external day services, and one resident had recently commenced an outreach programme which was reported to be going well. Residents who did not attend external day services were supported to do activities on a planned basis in a location near their home or were supported to do activities in their home. From discussions with residents, staff and a review of documentation it was found that residents enjoyed a range of activities in their home and in the community. These included 'chairobics', day trips, hotel breaks, attending music concerts, going to the gym, being part of a walking group, shopping, reflexology

and beauty treatments. However, improvements were needed in ensuring that all residents were supported to achieve personal social care goals in a timely manner. This will be discussed further in the report.

Throughout the inspection residents were observed to be relaxing in the sitting-room, kitchen and in their bedrooms. One house had an area in the hallway that had sensory lights and equipment and which one resident showed the inspector and they were observed to be relaxing in this area during the inspection. Throughout the day residents were observed using technological devices, watching television, going out on the bus, going for walks both independently and with support staff and having meals. Residents appeared content and comfortable in their homes and with each other.

However, it was observed in one house that an alarm device that was being used for one resident to monitor their movements sounded loudly in a communal area, which could impact on the other residents' quiet enjoyment of their home, as well as possibly impacting on the person themselves. Staff spoke about how an alternative device had been identified and was in progress to be delivered, and described how this would not impact on other residents. However, this had not been assessed appropriately to review that it was the least restrictive option, and to assess the impact on all residents.

The houses appeared homely, clean and spacious for the needs and numbers of residents. The homes were decorated with artwork, photographs and soft furnishings. There were notice boards in communal areas which displayed information for residents, such as posters about rights, advocacy, COVID-19 and keeping safe. There were colourful window boxes and potted plants observed around the houses and the gardens were colourfully decorated and contained garden furniture for residents to sit out in their garden. Some residents showed the inspector their bedrooms. They were observed to be comfortable and personalised with photographs and personal items. Some residents described how they chose the colours for their bedrooms and spoke about how they liked spending time in their bedrooms watching television and doing art work.

In general, the inspector found that the service strived to provide a quality, safe and person-centred service to residents. Some improvements were required to ensure that all residents were supported to achieve personal goals and that measures in use to reduce risks were appropriately assessed as to the impact they had on residents. The following sections of the report outline the governance and management and how this impacts on the quality and safety of care provided to residents.

Capacity and capability

Abbey Village group homes consisted of three houses all located within walking distance from each other. Each house provided full-time residential care to five

residents. This inspection was carried out to follow up on actions that were required to ensure compliance with the regulations as identified during an inspection by the Health Information and Quality Authority (HIQA) in 2021 and to monitor progress on the provider's actions arising from the targeted inspection programme completed in January 2022. On the last inspection significant risks were found to be not managed appropriately in one house. The provider submitted a comprehensive action plan to address the areas of non compliance.

The inspector found improvements on this inspection in the identification and management of risks, governance and management and in ensuring protection of residents. However, further improvements were required in staffing, staff training, achievement of some residents' personal goals, assessment of restrictive practices, systems for ensuring ongoing protection and some aspects of risk management. These will be discussed throughout the report.

The person in charge was available throughout the inspection, and the director of nursing (DON) was available on the telephone. The inspector spoke with a number of staff over the course of the inspection, in addition to having a phone conversation with the DON.

The DON informed the inspector about actions that had been implemented and actions that were currently in progress as part of the provider's action plan in response to the overview report arising from the targeted inspections in January 2022. It was reported that all committees that the DON were part of were currently in progress. Minutes of these meetings were not reviewed at the time of inspection, however the inspector was verbally assured that progress was made in implementing actions as outlined by the provider in the overview report.

The person in charge spoke about the county level management meetings and individual meetings with the DON, which they reported were beneficial. Minutes of these meetings were available for review in the centre and demonstrated that learnings from designated centres in the county were shared at these management meetings. In addition, the person in charge reported that they now met with the DON regularly to review incidents, centre risks and other relevant centre specific issues, and minutes of these meetings demonstrated that a comprehensive review of the centre took place and identified actions for improvements. The person in charge spoke about centre level team meetings, and about how three separate meetings, one for each location, was being completed. During discussion about this, that said that they were reviewing the schedule of these meetings to ensure that all meetings would be held as outlined in the overview report action plan.

The person in charge worked full-time and had responsibility for Abbey Village designated centre only. They were supported in their role by a Clinical Nurse Manager 1 (CNM1) who worked full-time in Abbey Village. The person in charge had the qualifications and experience to manage the centre and they appeared very knowledgeable about the needs of residents and the service. They reported that they were in the process of completing 'person in charge training' that was provided by the provider and they reported that they found this training very useful. In addition, they reported that they were attending training in 'incident management

and safeguarding training' the afternoon of the inspection. This was an action from the overview report that the provider had identified to comply with regulation 8 (protection) and was due to be completed by the end of April 2022.

Staffing arrangements were reviewed as part of the inspection. The skill mix in the centre included nursing staff and healthcare assistants. There was a planned and actual rota in place which indicated that there was appropriate numbers of staff on duty during the inspection to meet the needs of residents. However, at times there were gaps in staffing that was required to be filled by the person in charge. This included waking night cover at times. The inspector was informed that there were three staff nurse vacancies in the centre, and that this recruitment was in progress, but had yet to be completed. The filling of these vacancies would ensure that the appropriate numbers and skill-mix to meet the needs of the residents was in place at all times and would reduce the need for the person in charge to provide cover.

The provider had a list of mandatory training that staff were required to complete. The person in charge maintained a training matrix detailing whether staff had completed training, or were due for training. It was found that not all staff working in the centre were included on this matrix. It was found that a number of regular agency staff who worked in the centre were not included. This meant that not all mandatory training could be verified as completed during the inspection. The person in charge spoke about how actions were in progress to address this gap in training records for agency staff. In addition, there were gaps in some mandatory training programmes required by staff such as the practical aspect of fire safety and manual handling training for one staff, and behaviour management and 'supporting sexuality in supported settings (SASS)' for one staff. New staff that had commenced had been scheduled for training in fire safety for the start of June and were reported to not be working alone at this time. The person in charge spoke about the induction process for new staff and about how there was a checklist in place for oversight of sharing of information for new staff.

There were a number of management audits being completed in the centre which showed that there were arrangements for oversight and ongoing monitoring of the centre by the local management team and the provider. The provider had completed the annual review of the quality of the safety and care provided in the centre. This included consultation with residents and their advocates. The documentation of this consultation required review to ensure that no personal information was included on this. In addition, the provider ensured that unannounced six monthly audits were completed. The last unannounced provider audit had been completed in November 2021, and the person in charge informed the inspector that the DON had commenced one the previous week, and that this was not yet concluded. They confirmed that this visit was unannounced as required in the regulations.The person in charge had a schedule of audits for each location of the centre, which included regular audits in incidents, finances, medication, health and safety, restrictive practices and personal plans. While these audits were being completed regularly, they required improvements as they failed to pick up some actions for improvement as found on inspection. This included the identification and assessment of some restrictive practices and the ongoing review of residents' personal goals.

A review of incidents and practices in the centre indicated that the person in charge had submitted most of the notifications to the Chief Inspector of Social Services.as required in the regulations. However, not all restrictive practices had been included in the quarterly notifications. This related to sensor alarms utilised for one resident to monitor their movements due to falls risks.

Overall, the inspector found the management arrangements had been strengthened in the centre which led to improved outcomes for residents' safety and protection. However, further improvements were required to ensure effective identification of areas for improvement to achieve full compliance with the regulations and which would enhance the quality of care and support provided to residents.

Regulation 14: Persons in charge

The person in charge had the experience and qualifications to manage the designated centre. They were knowledgeable about the needs of residents and it was evident that residents were familiar with them.

Judgment: Compliant

Regulation 15: Staffing

The inspector was informed that were three vacancies for staff nurses in progress at the time of the inspection. The completion of this recruitment would ensure improved continuity of care to residents and reduce the need for the person in charge to cover shifts on the roster.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were gaps in the records maintained which made it difficult to verify that all staff supporting residents had completed the mandatory training programmes identified. Refresher and mandatory training were required for some staff in SASS, manual handling, fire safety and behaviour management.

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 the inspection the inspector was informed that all 10 meetings and committees had commenced. For example; the weekly county 'regulation, monitoring and governance meeting, chaired by the general manager, had been implemented. The inspector was informed that the 'Human Rights committee' had met in April and that the 'Policy, Procedure, Protocol, Guidelines (PPG) development group' had also commenced. With regard to the network level meetings, the inspector was informed that the 'governance for quality safety service improvement' meetings chaired by the DON had commenced and that that 'safeguarding review meetings' due to be held quarterly had occurred in February. The minutes of these meetings were not available in the centre for review by the inspector. However, the centre level meetings between person in charge and DON which had commenced had minutes available for review. The person in charge spoke about the benefit of meeting with the DON to review centre specific issues, and the minutes of the meetings demonstrated a comprehensive review with actions identified for completion. With regard to the staff governance meeting within the centre, the person in charge spoke about reviewing the schedule of this so that they can occur bi-monthly in line with the compliance plan.

However, the ongoing oversight and monitoring of Abbey Village required further improvements to ensure that the systems in place effectively identified areas for improvement to ensure a quality and safe service at all times.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Some restrictive practices had not been included in the quarterly notifications to the Chief Inspector as required in the regulations.

Judgment: Not compliant

Quality and safety

Improvements were found on this inspection in the quality and safety of care provided to residents since the previous inspection in 2021. Safeguarding and other risks that may impact residents were identified and assessed, with appropriate supports provided. However, further improvements were required in supporting residents to achieve personal social care goals, in implementing processes for ongoing protection as identified in the provider's action plan timeframes, in the assessment of some restrictive practices and in some aspects of risk management.

The inspector visited all houses and reviewed a sample of residents' care and support plans in each house. Residents were found to have comprehensive assessments of their health, personal and social needs completed. There were a range of support plans in place to guide staff in the supports required for specific assessed needs. From a review of documentation and discussions with staff, it was evident that residents were supported to achieve the best possible health and wellbeing. Residents were facilitated to access a variety of allied healthcare professionals and had access to multidisciplinary team (MDT) supports as required. There was evidence of MDT supports and regular meetings occurring to provide ongoing supports and oversight in the management of some risks affecting residents' health and wellbeing.

Residents had annual review meetings completed, which included maximum consultation with residents and their representatives where relevant. Residents were supported to identify personal goals for the future. Some of these goals included going to musicals, attending concerts, going on holidays and getting beauty treatments. In general, goals were found to be kept under review to ensure that they were achieved. However, for one resident whose personal goal was to go out on more bus trips, it was found that this was plan was not appropriately reviewed to ensure that it was effective and achieved. A progress note completed in May stated that the resident goes on bus trips at least once per week or fortnight, however records available did not support that this was occurring. For example; the resident had identified this goal at a meeting during the first week in February, and a review of records and discussions with staff showed that the resident had only been out on a bus trip five times since March. Improvements were required to ensure that all residents' personal goals were achievable and reviewed appropriately as to their effectiveness.

A review of safeguarding practices in the centre found that residents were safeguarded against any potential abuse. Where concerns arose, these were followed up through the safeguarding procedures. Safeguarding plans were found to be developed as required, and kept under regular review. Residents had comprehensive intimate and personal care plans to guide staff in appropriate supports to be provided in this area in line with residents' preferences and individual needs. Residents spoken with said that they felt safe in the centre and that they liked where, and with whom, they lived. There were easy-to-read documents available for residents to help support their understanding of keeping safe. In addition, regular house meetings occurred where discussions about keeping safe occurred. Staff spoken with were aware of what to do if a safeguarding concern arose. Safeguarding and a review of incidents was also discussed between the person in charge and DON at their meetings. However, improvements were required

to implement actions identified by the provider in the overview report within the timeframes outlined, which would enhance the protection of residents on an ongoing basis.

Residents that required supports with behaviours of concern had care and support plans in place. A review of behaviour support plans found that these were comprehensive and included strategies for staff to support residents with specific behaviours. Plans were up-to-date and kept under regular review for any changes that may be required. One residents plan was noted to be in progress for review with the relevant multidisciplinary team member, following the completion of behaviour charts to assess the possible cause of the behaviours.

The inspector reviewed restrictive practices in one location. It was found that some restrictive practices in place to monitor a residents' movements had not been appropriately assessed to ensure that it was the least restrictive measure and proportionate to the risks. This related to sounding alarms, one of which alerted staff if a resident got up from a chair which was located in the communal area. The inspector observed that this alarm was very loud and could impact on the resident and other residents' quiet enjoyment of their home. Following discussion with staff and the person in charge, it was found that while there had been MDT input in agreeing the use of these to reduce risks, there was no assessment completed to review that this was the least restrictive option for the resident or to assess the possible impact on others in the home. It was noted that the resident's assessments of need stated that they required one-to-one staff while in the house and following discussion with staff they confirmed that this was in place. While the inspector was informed that an alternative device was being sourced that would not make a loud noise, the assessment of the use of restrictive practices required review to ensure that they were proportionate to the risks identified and that they were the least restrictive option for the shortest duration.

The management of risk had improved since the last inspection. Each location in the designated centre had its own specific risk register, and where risks were identified for residents these had been assessed with control measures put in place. Improvements were required in ensuring risk ratings were inputted in line with the provider's policy and procedures and that they included a clear description of the risk to inform the ratings assigned. In addition, one risk assessment relating to the management of epilepsy required updating to reflect recent training that had been completed by healthcare staff.

In summary, the inspector found that the protection and management of risk to residents had improved and that residents were provided with good care and support. Improvements in the monitoring of the achievement of personal goals, in implementing robust processes for ongoing protection and in assessing restrictive practices would enhance the quality of care and support provided.

Regulation 26: Risk management procedures

While risks were found to be well managed, some risk assessments required review and updating to ensure that the risk descriptions were clear and that risk ratings were included, in line with the organisation's procedures.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The review of some residents' personal goals required improvements to ensure that the goals identified were specific, achievable and completed in a timely manner and that the plan was effective.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to achieve optimal health and wellbeing, by being facilitated and supported to access a range of allied healthcare professionals and MDT supports, as required.

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.

Not all actions were reviewed by the inspector during this inspection; however, a the time of the inspection the inspector was informed that the one action relating to the approval for additional for MDT supports was in progress. There was evidence also that another action which related to the review of training was also discussed at person in charge and centre level meetings. In relation to three actions regarding induction of new staff, the inspector was informed that the induction process in the centre had been reviewed with the person in charge and DON and was found to be fit for purpose, and that the same induction checklist was used for new staff and employees assigned at short notice.

However, some restrictive practices in place in one location of the centre required review to ensure that they were assessed as being the least restrictive option and used for the shortest duration and that the impact on residents and others were included as part of this assessment.

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 ten actions at this time. At the time of the inspection five actions were in progress, three that related to training had dates set or were awaiting dates (for one staff for SASS training) and two actions were completed (safeguarding review meetings and review of training schedules).

However, not all actions had been completed within the timeframe outlined in the overview report action plan. For example; the inspector was informed by the DON that the safeguarding tracking log to monitor active safeguarding cases was in progress at present, but had been due for completion by the end of March 2022. In addition, a review of the audit schedule and audit tool for safeguarding was due to be completed by the end of April 2022, and this was reported to be in progress. The 'Incident Management & Safeguarding Training' for all persons in charge which was due to be completed by the end of April 2022, was reported to be scheduled for the day of inspection.

Training in the completion of preliminary screenings was due for completion by the end of May 2022, and the inspector was informed that a date had been set for this. One staff required training in SASS and the person in charge was awaiting a date for this. In relation to a 'Policy on the provision of safe WiFi usage', this was reported to be in progress for completion. The person in charge was aware that a peer support structure for designated officers would be implemented and they reported that they would be completing training to be a designated officer.

The safeguarding review meetings had been implemented and the person in charge spoke about the benefit of this in sharing information and providing opportunities for shared learning from safeguarding concerns. In addition, training needs were reviewed at centre and person in charge level.

The impact of the provider's plan for enhanced oversight and monitoring as detailed above was not yet evident, as these processes were in the early stages or were not yet implemented. However on the day of inspection, the inspector found that safeguarding measures and processes in the centre now ensured that residents' safety was promoted and regularly reviewed.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Abbey Village Group Homes OSV-0005250

Inspection ID: MON-0036249

Date of inspection: 18/05/2022 and 19/05/2022

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: • To strengthen the overall Governance and Management of this Designated Centre a Clinical Nurse Manager 1 has commenced in post from 06/12/2021. • Three additional staff nurse posts have been approved and are awaiting appointment of personnel by HR. • A recruitment campaign for staff nurses within disability services inclusive of graduate nurses who will qualify October/November 2022 has commenced with interviews planned for week commencing 27/06/2022.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with regulation 16: Training and staff development: the following actions will be undertaken • Supporting Sexuality in Supported Settings - 1 staff require this training. This training is scheduled for 29/06/2022. • Manual handling - 3 staff require this training. This training is scheduled for 30/06/2022.	

• Fire Safety - 1 staff require this training. This training is scheduled for 08/07/2022.

• Positive Behavior Support – 3 staff require this training. This training is scheduled for 27/06/2022 & 28/06/2022.

• The person in charge maintains a training matrix for a number of agency staff who work in the centre. Completion date: 30/05/2022

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 undertaken

• The minutes from the quarterly safeguarding review meetings are onsite in all three houses. Completion date: 28/05/2022

• The quarterly quality safety service improvement meetings chaired by the DON have commenced and the minutes from these meeting are onsite in all three houses. Completion date 25.05.2022. A schedule of meetings is set out for the remainder of the year.

• Bi-monthly staff meetings are taking place within the centres attended by PIC, CNM2 and all staff working within the centres as appropriate. Dates for these meetings have been scheduled for the remainder of the year. Completion dates 01.06.2022, 08.06.2022, 10.06.2022.

• The use of a bed alarm and chair alarm will be included in the quarterly notifications to HIQA for the centre. Completion date: 31/07/2022

• The restrictive practice log for the centre has been reviewed and updated to include the bed alarm and chair alarm. Completion date: 02/06/2022.

• A risk assessment has been completed for the use of the bed/chair alarm to ensure the least restrictive option is used for the shortest duration and that the impact on residents and others is considered. Completion date: 02/06/2022

• The centre has a Health and Safety statement which identifies all risks in the centre and control measures in place to mitigate risks identified. The risks will be reviewed quarterly or sooner if required. Completion 15.03.2022.

• Individual risk assessments are under review by the PIC, CNM1 & staff nurses within the three Community Group Homes to ensure risk descriptions and risk ratings are accurately recorded. Completion date : 13/06/2022

• The behavior support plan for one resident has been completed following MDT assessment. Completion date: 26/05/2022

• Supporting Sexuality in Supported Settings - 1 staff require this training. This training is scheduled for 29/06/2022.

• Positive Behaviour Support – 3 staff require this training. This training is scheduled for 27/06/2022 & 28/06/2022.

• Additional MDT support. – National approval to recruit Health & Social Care Professionals for Donegal has been secured as follows:
- 2 senior Social Workers
- 2 senior Speech and Language Therapists
- 2 senior Psychologists

Recruitment is being progressed by HR.

• All person centered plans have been reviewed by the PIC, CNM1, staff nurses and key workers to ensure all goals are being met within agreed timeframe. Completion date: 09/06/2022

• Safeguarding tracking log is in place which monitors all active safeguarding cases. Completion date 19.05.2022.

• The Regional Director of Nursing has completed a review of the audit schedule. Completion date: 30/04/2022. A number of actions have been identified following the review and these are currently in progress to be closed out by the 30/09/2022.

• The incident Management & Safeguarding Training for all persons in charge has been completed. Completion date: 19/05/2022.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To ensure compliance with regulation 31: Notification of Incidents: the following actions will be undertaken

• The use of a bed alarm and chair alarm will be included in the quarterly notifications to HIQA for the centre. Completion date: 31/07/2022

• The restrictive practice log for the centre has been reviewed and updated to include the bed alarm and chair alarm. Completion date: 02/06/2022.

• A risk assessment has been completed for the use of the bed/chair alarm to ensure the least restrictive option is used for the shortest duration and that the impact on residents and others is considered. Completion date: 02/06/2022

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: the following actions will be undertaken

• The centre has a Health and Safety statement which identifies all risks in the centre and control measures in place to mitigate risks identified. The risks will be reviewed quarterly or sooner if required.

• Individual risk assessments are under review by the PIC, CNM1 & staff nurses within the three Community Group Homes to ensure risk description and risk rating is accurately recorded. Completion date: 13/06/2022

• The use of a bed alarm and chair alarm has been included in the centres restrictive practice log. Completion date: 02/06/2022.

• A risk assessment has been completed for the use of the bed/chair alarm to ensure the least restrictive option is used for the shortest duration and that the impact on residents and others is considered. Completion date: 02/06/2022.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
To ensure compliance with regulation 5: Individual assessment and personal plan: the following actions will be undertaken

• All Person Centered Plans have been reviewed by the PIC, CNM1, staff nurses and key

workers to ensure all goals are being met within agreed timeframe. Completion date: 09/06/2022

• The behavior support plan for one resident has been completed following MDT assessment Completion date: 26/05/2022

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: Positive behavioral support: the following actions will be undertaken

• The behaviour support plan for one resident has been completed following MDT assessment Completion date: 26/05/2022

• Supporting Sexuality in Supported Settings - 1 staff require this training. This training is scheduled for 29/06/2022.

• Positive Behaviour Support – 3 staff require this training. This training is scheduled for 27/06/2022 & 28/06/2022.

• Additional MDT support. – National approval to recruit Health & Social Care Professionals for Donegal has been secured as follows:
· 2 senior Social Workers
· 2 senior Speech and Language Therapists
· 2 senior Psychologists
Recruitment is being progressed by HR.

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 undertaken

• Supporting Sexuality in Supported Settings - 1 staff require this training. This training is scheduled for 29/06/2022.

• Safeguarding tracking log is in place which monitors all active safeguarding cases. Completion date 19.05.2022.

• The Regional Director of Nursing has completed a review of the audit schedule. Completion date: 30/04/2022. A number of actions have been identified following the review and these are currently in progress to be closed out by the 30/09/2022.

• The incident Management & Safeguarding Training for all persons in charge has been completed. Completion date: 19/05/2022

• The minutes from the quarterly safeguarding meetings are onsite in all three houses. Completion date; 28/05/2022

• The service is currently developing a Donegal policy on the provision of safe Wifi usage in conjunction with the Digital Health Lead, Health and Social Care Professionals and in consultation with other care group services. Completion date: 31/12/2022

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	31/12/2022
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	31/08/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/12/2022

	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	31/07/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a	Substantially Compliant	Yellow	09/06/2022

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	02/06/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	02/06/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022