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:	Dunshenny House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	12 February 2024
Centre ID:	OSV-0007987
Fieldwork ID:	MON-0042672

About the designated centre

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

Dunshenny House provides full-time residential care to adults with moderate to severe intellectual disability. The service comprises one building which is located in a rural area, close to a busy town. Residents are supported with co-existing conditions such as mental health illness and/or behaviours of concern, special communication needs, physical illness and conditions such as epilepsy and diabetes. Dunshenny House is accessible for people who are wheelchair users. Residents are supported by a qualified team of nurses and healthcare assistants who provide 24 hour care. Active night duty arrangements are in place.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 12 February 2024	09:15hrs to 17:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor and review the arrangements that the provider had in place in order to ensure compliance with the Care and Support Regulations (2013). The inspection was completed over one day and during this time, the inspector met with residents and a family member, and spoke with staff. In addition to discussions held, the inspector reviewed the documentation at the centre and observed the daily interactions and the lived experiences of the residents living at Dunshenny.

At the time of inspection, there were three residents living at Dunshenny House. These residents had a range of high support needs and one resident had significant risks relating to behaviours of concern. The provider demonstrated their ability to manage these concerns very well in the past. However, the service was experiencing a period of ongoing change in leadership and management and that this had a significant impact on the residents, the staff and the quality of the service provided. In addition, the service was experiencing challenges in relation to the recruitment of healthcare assistants and nursing staff and was heavily reliant on agency staff. This impacted on the provider's ability to deliver a consistent service to the residents living at Dunshenny House. The provider was aware that consistency of care and support was critical to the delivery of a good quality and safe service and had taken action in order to manage and eliminate these risks. The inspector noted the improvements made and the positive impact that they had on the centre. However, ongoing work was required in relation to staffing, training and development, positive behaviour support, safeguarding processes, risk management and overall governance, management and oversight at the centre in order to return to compliance.

A walk around of the building was completed by the inspector who found that the residents were provided with a pleasant, welcoming and comfortable home. Each resident had their own bedroom and bathroom facilities. In the main house, there was a combined kitchen and dining room which was well equipped to meet with the residents needs. The sitting room was nicely decorated with framed photographs and comfortable furnishings, all which helped to create a warm and cosy environment. The annex provided a suitable home for the resident living there. Colourful homemade cards were displayed and the rooms were cheerfully decorated. A garden space was provided which provided additional space for the residents' used during the warmer weather. Dunshenny House was located within walking distance of a busy town. In addition, transport was provided which meant that the residents could travel to other towns and to the local beaches and scenic areas if they wished to do so.

The inspector met with all residents during the inspection. One resident was preparing to leave the centre to attend a medical appointment. Due to the resident's high support needs, they were accompanied by a staff nurse and a healthcare assistant. The inspector observed an additional staff nurse that arrived at the centre

at that time. The person in charge explained that they were a bank nurse and their role was to provide short term cover for the staff nurse who was departing the centre with the resident. The arrangement commenced in December 2023 and was an example of the action taken by the provider in response to the staffing challenges that they were experiencing at that time. The resident returned from their appointment later that day and the bank nurse departed the centre. The resident appeared content and they were observed as they prepared for a trip to their family home that afternoon. The inspector had an opportunity to speak briefly with the resident's family member before they departed. They said that their relative was very happy when leaving the designated centre but equally happy when returning after a home visit. They said that the care and support provided by the staff team was very good.

The second resident was enjoying a sleep in as the staff explained that they did not always sleep well at night time. They rose later that morning and were observed as they prepared for their day. The interactions between the resident and the staff on duty were caring and respectful. The third resident lived in the annex where they were supported by two staff members. They invited the inspector into their home for a short visit. This resident was reported to like routine which included a morning walk as the weather was pleasant. The staff on duty at the time of inspection were found to be familiar with the resident's likes and dislikes and they were observed supporting the resident in a kind and respectful manner.

The inspector found that the residents living at this designated centre were provided with good quality care and support by the staff on duty. It was very clear that the staff were keen to do a good job. For example, the resident that attended a medical appointment that morning had specific medical needs. They required a medical assessment to be completed by the general practitioner (GP) which had the potential to be stressful for the resident and the staff. The nurse on duty explained the supportive actions that they took to ensure that the resident was comfortable with the process. The assessment was successful and as outlined the resident was observed as happy and content on their return to their home.

During the course of the inspection, the inspector spoke with the person in charge and five staff members. All staff spoke about the constant change in the leadership arrangements in the centre and the difficulties in staff recruitment. They said that the final quarter of 2023 was very stressful. This was due to ongoing changes in staff and a lack of consistent care and support. However, staff spoken with told the inspector that there was a significant improvement in the past month as although the service continued to be reliant on agency nursing staff, that they were consistent now. In addition, they said that the bank nurse arrangement was working well. Residents were happier now and they were able to do things in their community again.

When asked, staff spoke with the inspector about human rights training. They told the inspectors that access to online training was provided and that they found it interesting and supportive. They spoke about ensuring that residents had the right to have what they needed and to make their own decisions. One staff member spoke about the resident that experienced behaviours of concern. They said that

this was the resident's 'own emotions' and that they had a right to express them in their 'own way'. Another staff member spoke about equality of rights and of how to promote the best options but ultimately that residents had the right to make their own choices.

From what the inspector observed and from discussions with staff members it was clear that the provider had experienced a period of crisis last year. However, at the time of inspection improvements were evident. However, change was ongoing in the centre and further action was required in order to sustain the improvements into the future. This included actions in relation to staffing, training and development, positive behaviour support, safeguarding processes, risk management and overall governance, management and oversight at the centre.

These matters will be expanded on in the next two sections of this report which will outline the findings of this inspection in relation to the governance and arrangements in place in the centre and how these impacted on the quality and safety of the residents' lives.

Capacity and capability

As outlined, the provider of this service experienced a time of crisis last year which resulted in staff vacancies, increased challenging behaviours and changes in the management and leadership of the centre which were ongoing. The inspector found that the provider responded to these issues by putting additional measures in place which were having a positive impact on the service at the time of inspection. However, further actions were required to ensure that the improvements were sustained and that consistent quality care and support was provided for the residents.

The staffing arrangements in place at the time of inspection were in line with the needs of the service and the statement of purpose. A sample of rosters were reviewed and they provided an accurate reflection of the staff on duty at the time of inspection. Although the service remained reliant on agency staff, the inspector found that they were regularly working at the centre. This meant that consistency of care and support was provided which was in line with the requirements of the risk assessment, a behaviour support plan and the recommendations of the multi-disciplinary team. In addition, the bank nurse arrangement was working well. The provider had a risk assessment in relation to risks of insufficient staff which documented the impact that this had on the service. However, this was closed recently. The risk was not managed at the level at which it could materialise and this required review.

Staff had access to appropriate training, including refresher training, as part of a continuous professional development programme. A staff training matrix was maintained which included details of when staff had attended training. However, not all refresher training modules were up to date and this required review. In addition,

the provider had a formal schedule of staff supervision and performance management in place. Not all supervision meetings had taken place in line with the requirements of the provider's policy.

As outlined, the governance, management and oversight arrangements at the centre were subject to ongoing change. Five persons in charge were employed over the past 12 months and the current person in charge was due to commence statutory leave in the immediate future. At the time of inspection, the provider did not have a clear plan in place to fill this vacancy and staff spoken with expressed concern in relation to the ongoing changes. This will be further expanded on under regulation 32 below.

The provider had an audit system in place. This included an annual review of care and support and a six monthly provider-led audit which were up to date. Although a quality improvement plan was in place it required review to ensure that it was accurate. In addition, and in response to the concerns arising last year, the provider completed a bespoke management audit in October 2023. This provided a comprehensive review of the service with actions to be completed by named staff within a target timeframe. However, due to the ongoing changes in the centre, the inspector found that many of the actions specified were not completed as recommended and remained outstanding at the time of inspection. In addition, the safeguarding and protection team identified a concern in relation names documented on a safeguarding and protection document. This concern was raised with the provider in summer 2023, however, was not yet actioned at the time of inspection. The overall governance and management arrangements in place required review to ensure that the oversight of the documentation systems was established and effective.

A review of incidents occurring found that they were notified to the Chief Inspector if warranted. However, although the provider was aware of the proposed absence of the person in charge, they failed to ensure that appropriate notification was submitted within required notice period. In addition, at the time of inspection, there was no plan to ensure that the centre had appropriate management arrangements in during this planned absence.

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

Regulation 15: Staffing

Although appropriate staffing arrangements were in place at the time of inspection, the service was reliant on agency staff to support the running of the service. In addition, the provider was aware of the risks that insufficient staffing posed. However, a risk assessment in relation to staffing concerns was closed recently despite the fact that staff vacancies remained. The following required review;

- To ensure that consistency of care and support is provided in line with the statement of purpose and with the recommendations of safeguarding and protection plans and the multi-disciplinary team.
- To ensure that risks in relation to nursing staff are effectively management, in order to ensure that nursing staff are available to meet with the assessed needs of the residents and in line with the statement of purpose provided.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had arrangements in place to support the training and development of staff. Staff spoken with were knowledgeable and aware of what to do if required. Although all staff had completed mandatory training, some refresher modules required updating. The following required review;

- To ensure that all refresher training modules were up to date. To include fire training, positive behaviour support training and safeguarding and protection training.
- To ensure that all staff were provided with a formal programme of supervision, including supervision meetings, in line with the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre were subject to ongoing change. Although the provider had made improvements, ongoing effort was required to ensure that the role of person in charge was established in the centre. In addition, the improvements made needed to be embedded in service delivery, effectively monitored and subject to regular review. The following required review;

- To ensure that consistency of care and support was provided.
- To ensure that all refresher training modules for staff are up to date in line with the providers' policy and that all staff have supervision meetings completed.
- To ensure that audits were completed in line with the provider's policy, were effective and were regularly reviewed. Where audits were completed, to ensure that time frames were specified, action owners named and if actions were outlined that these were addressed promptly.
- To ensure that documentation held at the centre was subject to regular review of clarity and consistency, and align to local and national policy. This includes care plans, risk assessments and safeguarding and protection

documents.
- To ensure that the risk management tools were updated to the new format as recommended in the management audit completed in October 2023 and in line with the due dates provided.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the incidents occurring found that notifications were reported to the Chief Inspectors in a timely manner and in accordance with the requirements of the regulation.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider failed to notify the Chief Inspector of the proposed absence of the person in charge in no later than one month before to the proposed absence.

Judgment: Not compliant

Quality and safety

As outlined, the inspector found that the care and support provided in Dunshenny House was good quality. It was provided by a dedicated staff team and environment met with the residents assessed needs. However, during a recent three month period, a resident living at the centre experienced a decline in their mental health that resulted in a significant increase in behavioural incidents. This was exacerbated by staffing challenges experienced at that and changes in the person in charge which were ongoing. As outlined, the provider had taken action to address these matters. However, ongoing works was required in relation to staffing, training and development, positive behaviour support, safeguarding processes, risk management and overall governance, management and oversight at the centre in order to ensure that the service delivered was of good quality and safe.

The resident's living in this centre were supported to achieve the best possible health and wellbeing outcomes. Where health care support was recommended and required, residents were facilitated to attend appointments in line with their assessed needs. For example; general practitioner (GP), clinical nurse specialists,

physiotherapist and occupational therapy. Access to consultant-led care was provided.

As outlined, a resident at this centre required support with complex behaviours of concern. Access to behaviour support specialists was provided and the provider's policy on behaviour support was up to date. However, the inspector found that although the staff were knowledgeable in relation to the proactive support measures in place, the oversight of the behaviour support process was not always effective.

The provider had arrangements in place to ensure that residents were protected from abuse. A safeguarding and protection policy and intimate care policy was in place. However, although residents were safeguarded at the time of inspection, the safeguarding and protection processes reviewed were not in line with local and national policy. In addition, guidance in relation to specific intimate care tasks required attention to ensure that it was specific and consistent across all guidance documents used.

The provider had systems in place for the assessment and management of risk, which included risk management policies, a service level risk register and individual personal risk assessments. However, the inspector found that these systems lacked oversight and were not effective.

In summary, the residents living at this designated centre had a range of assessed needs including complex and high-risk behaviours of concern. They were provided with a good level of care and support by a dedicated staff team. However, the provider was required to make improvements that ensured that the improvements at the centre were further built upon, and consistency of oversight and governance was established and maintained.

Regulation 26: Risk management procedures

The provider had systems in place for the assessment and management of risk, which included risk management policies, a service level risk register and individual personal risk assessments. However, the inspector found that these systems lacked oversight and therefore not always effective. For example;

- A risk assessment in relation to staffing concerns was closed recently which was not in line with provider's policy and when vacancies in the staff team remained.
- Risk assessments were out of date, not always accurate, incomplete, and not subject to regular review. These included risk of serious incidents of self-injurious behaviour, using objects as weapons and risk of violence towards staff and others. These gaps were identified by the management audit completed by the provider but the improvements recommended were not actioned.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health and wellbeing. Staff spoken with were knowledgeable and proactive in supporting residents' healthcare needs. Where health care support was recommended and required, residents were facilitated to attend appointments in line with their assessed needs. This included GP, nurse specialists, multi-disciplinary care and consultant-led care if required.

Judgment: Compliant

Regulation 7: Positive behavioural support

A resident living at this designated centre required support with complex and high risk behaviours of concern. Access to behaviour support specialists was provided and the provider's policy on behaviour support was up to date. At the time of inspection, the inspector noted significant improvements in the consistency of care and support provided which resulted in a reduction in the incidents occurring. However, the provider need to sustain these improvement. At the time of inspection, lack of oversight meant that the systems and processes in place were not always effective. For example;

- The resident's updated positive behaviour support plan was not available in the centre. This was completed in November 2023. The person in charge ensured that it was made available on the afternoon of inspection.
- Not all staff had completed refresher training in positive behaviour support in line with the recommendations of the positive behaviour support plan, the recommendations of the multi-disciplinary team and the risk assessments in place.

Judgment: Not compliant

Regulation 8: Protection

The provider had arrangements in place to ensure that residents were protected from abuse. A safeguarding and protection policy and intimate care policy was in place. However, although residents were safeguarded at the time of inspection, the following required review;

- Not all staff had up-to-date training in safeguarding and protection.

- Safeguarding and protection processes reviewed were not in line with local and national policy. They were not always accurate, were incomplete and were not subject to audit to ensure effectiveness.
- Guidance in relation to specific intimate care tasks required attention to ensure references to gaining consent were specific, that the guidance for staff was clear and that it was consistent on all relevant documentation.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Dunshenny House OSV-0007987

Inspection ID: MON-0042672

Date of inspection: 12/02/2024

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 ensure compliance with Regulation 15: Staffing, the following actions will take place • The Person in Charge (PIC) will complete a review of staffing levels within the Centre on an ongoing basis to ensure all absences are replaced to ensure staffing levels remain within the assessed numbers set out in the centres Statement of Purpose. • Staff Nurse Position has been offered out to the current panel, in the interim vacancy is being filled by bank nurse from within the centres nursing staffing compliment. • Senior Management are currently working with the Human Resource Department and have attended recent employment fares with further fares planned in an additional efforts to recruit staff to the service. • PIC has completed a Risk Assessment in relation to staffing which will remain open and kept under constant review. Completed 14.03.2024.	
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 taken.	

• PIC has reviewed the centres training matrix.
• A training plan has been provided for each member of staff who will have completed all mandatory HSELand training by 30/04/2024.
• Manual Handling Training has been scheduled for one remaining outstanding staff member on 28/03/2024.
• CPR training for all staff will be completed by 28/03/2024.
• PIC has scheduled dates for Studio 3 training for one remaining outstanding staff member. Completed on the 15.03.2024
• PIC has scheduled performance achievement meetings with all staff. All performance achievement meetings will be undertaken by 03/04/2024.

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

• The Assistant Director of Nursing for Inishowen is the current PIC for this centre

• PIC has reviewed the training matrix and has completed a training needs analysis, which has been provided to each staff member with dates for completion of outstanding training identified 30/04/2024.

• In addition to PIC monitoring a monthly audit of the training matrix will be undertaken by CNM3 Quality Safety & Service User Safety to support governance of training within the centre.

• The PIC is currently reviewing all risk assessments within the centre to include staffing and individual resident's risks. This review will ensure that all risks identified accurately reflect the current status from both a centre and resident perspective and that they are rated appropriately. All risks within the centre are reviewed quarterly or sooner if required. Date to be completed 31/03/2024.

• All Audits will be completed as per CH CDLMS audit schedule and actions that arise will be added to centres QIP and closely monitored until closed out.

Regulation 32: Notification of periods	Not Compliant

when the person in charge is absent	

Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:
To ensure compliance with Regulation 32: Notification of periods when the person in charge is absent the following actions will be taken

• The PIC will notify the Chief Inspector within the specified timeframe of any absence of the person in charge.
• PIC planned absence submitted 13.03.2024

Regulation 26: Risk management procedures	Not 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

• PIC has completed Risk Assessment for minimum staffing levels for the centre 14.03.2024.

• The PIC has reviewed all risk assessments within the centre to include centre and individual resident's risks. This review will ensure that all risks identified accurately reflect the current status from both a resident and centre perspective and that they are rated appropriately and in line with policy. Date for completion 31/03/2024

• Each resident's care plan will be audited, inclusive of individual risk assessments with 3 monthly evaluation to be undertaken thereafter. Any actions identified will be monitored and closed off within specified timeframes. Date for completion 31/03/2024

• A selection of the residents care plans were audited by Nurse Practice Development on the 20.02.2024.

• Actions from Nurse Practice Development audit added to centres QIP with closing date for 30/04/2024

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: To ensure compliance with Regulation 7: Positive behavioural support: the following actions will be taken • The PIC will ensure going forward when resident's positive behaviour support plan are updated that a copy is availabe on site for all staff. Updates will be brought to the attention of all staff with a request to read and sign same. A staff meeeting to discuss the HIQA inspection and findings of same was held on 21.03.2024. Positive behaviour support plans were discussed and it was highlighted that PIC/Named Nurse will ensure that positive behaviour support plans will be made available on site • The PIC will ensure that all staff complete refresher training in positive behaviour support in line with the recommendations of the positive behaviour support plan. This has been included within the site specific training requirements and monitored by the PIC.	
Regulation 8: Protection	Not 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; • PIC has reviewed the training matrix and has completed a centre training needs analysis. Personal training plan to include safeguarding has been provided to each staff member. All staff have completed safeguarding training since 15.03.2024. • The PIC will ensure that all centre safeguarding and protection processes are reviewed in line with local and national policy and audited as per agreed audit schedule. • The PIC will ensure that intimate care plans for individual residents are specific and that consent is detailed and specific to each individual needs.	

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	31/03/2024
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	30/04/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	03/04/2024

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	31/03/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/03/2024
Regulation 32(1)	Where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more, the registered provider shall give notice in writing to the chief inspector of the proposed absence.	Not Compliant	Orange	13/03/2024
Regulation 32(2)(b)	Except in the case of an emergency, the notice referred to in paragraph (1) shall be given no later than one month before the proposed absence	Not Compliant	Orange	14/03/2024

	commences or within such shorter period as may be agreed with the chief inspector and the notice shall specify the expected dates of departure and return.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/03/2024
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	15/03/2024
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the	Not Compliant	Orange	15/03/2024

	resident's dignity and bodily integrity.			
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	15/03/2024