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: | St Dominic's Services |
|---|---|
| Name of provider: | Ability West |
| Address of centre: | Galway |
| Type of inspection: | Unannounced |
| Date of inspection: | 18 October 2023 |
| Centre ID: | OSV-0001507 |
| Fieldwork ID: | MON-0041321 |

## About the designated centre

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

This designated centre is operated by Ability West and can provide residential and respite care for up to seven residents, who are over the age of 18 years and who have an intellectual disability. Six beds are for residential care and an additional bed is used to provide a respite service. The centre is located within a town in Co. Galway and comprises of one large bungalow dwelling. Each resident has their own bedroom, shared bathrooms and all have communal use of a sitting room, kitchen and dining area, sensory room, laundry room and there is also a staff office. A garden area surrounds the centre, which residents can access, as and when they wish. The centre can support residents with reduced mobility, with tracking hoist, wheelchair accessible ramps and transport available. The residents of this service are supported by a combination of social care workers and care assistants, with staff on duty each day to support the residents who live in this centre.

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

| Number of residents on the date of inspection: | 6 |
| --- | --- |

## 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 October 2023 | 10:30hrs to 15:00hrs | Ivan Cormican | Lead |
| Wednesday 18 October 2023 | 10:30hrs to 15:00hrs | Anne Marie Byrne | Support |

## What residents told us and what inspectors observed

This was an unannounced inspection to follow up on the actions taken by the provider following poor levels of compliance on a previous inspection. The provider had previously been issued with a warning letter informing them that if they did not improve the standard of support and care to residents in this centre, the Chief Inspector would give consideration to cancelling the registration of the centre.

Up until 2022, inspectors had overall found that residents had a good standard of care and support in this centre. In April 2022, following receipt of information of concern, inspectors required the provider to submit an assurance report in which the provider stated that they were establishing a task force to review the service and the needs of residents to ensure they continued to be provided with supports that were appropriate to their changing needs. Inspectors followed up with an inspection of the centre on 2nd December 2022 to verify that the provider had implemented their actions. Inspectors found that the provider had not established the Task Force, had not undertaken a review of the supports to residents and in addition, inspectors found concerning levels of non-compliance in fire safety. The provider was required to take immediate and urgent action to address those issues. In addition, there were non compliances in governance and management, person in charge arrangements and staffing arrangements, all of which were impacting negatively on the quality of support for residents.

In January 2023, the provider was issued with a warning letter which stated that the Chief Inspector would give consideration to the cancellation of the centre's registration if the provider failed to improve the quality and safety of support for residents and bring the centre into regulatory compliance. The provider submitted a compliance plan to the inspection report setting out the actions they would take and in addition, submitted an overall organisation-wide governance improvement plan in April 2023. Significant actions in the compliance plan and governance improvement plan were to be completed by September 2023 and this inspection was undertaken to verify whether the provider's actions had resulted in improvements for residents and improved regulatory compliance.

Six residents lived in this centre, with five of them already having left for their day service, prior to the inspectors' arrival. One resident remained, and they were being supported by a staff member to have their day service in the comfort of their own home. Although this resident didn't engage much with the inspectors, they were observed to move at their ease from room to room, and appeared comfortable in the company of the staff member supporting them. Much of the inspectors' time was spent with the person in charge and team leader who spoke at length about the care and support that all six residents received.

These six residents had lived together for a number of years, some were of an aging profile and their care and support needs were changing significantly. They needed on-going care and supervision from staff. All of the residents in the centre required

support with their personal and intimate care, some needed support at mealtimes, all required staff support to get out and about, some had manual handling needs, on-going positive behaviour support was required by some, others had visual impairments, all had limited verbal communication skills, while others required specific falls management interventions. Since the last inspection, due to staffing resources, the provider had ceased the operation of respite within this service.

The general layout of this centre was very spacious, with ample seating in the sitting room and in the kitchen and dining area, making it comfortable for residents to sit and interact with one another. Both the team leader and person in charge told of how residents got on well, and sometime sat together in the sitting room to watch various musicians and singers on television.

While inspectors found that the provider had sustained their improvements in fire precautions following the previous inspection, overall there was a deterioration in compliance levels in the centre and these are discussed in the body of the report below.

## Capacity and capability

This was an unannounced inspection carried out to verify that the provider had implemented their actions for improvement in the compliance plan following the previous inspection and in the governance improvement plan that was submitted to the Chief Inspector, and to verify whether those actions had brought about improvements in the quality and safety of care and support in the centre.

Overall, inspectors found that a failure to improve governance and management arrangements had a profound impact on the service residents received with a clear lack in the provision of consistent staffing over two consecutive inspections of this centre. In addition, the provider failed to ensure that the healthcare and safety arrangements for residents were being kept up to date and changing care needs were being responded to in a timely manner. For example, inspectors read about a resident who was experiencing an increased number of falls including a requirement to attend for medical attention and the provider had not ensured a recent informed review by an appropriate health professional had occurred. Furthermore, regulations such as personal planning and risk management which had shown a good level of compliance on the last inspection of this centre, had regressed with both regulations deemed as not compliant. Inspectors found that the provider had failed to implement most of the actions that they had committed to in their compliance plan and in their governance improvement plan.

Residents who use this service could be considered part of an aging population and as such their care needs have increased over time and all residents required support with personal care, maintaining safety, nutrition, heath and also social care.

Inspections which have been conducted from April 2022 have shown a significant decrease in the quality and safety of care which was provided and inspectors found on this inspection that the provider's oversight arrangements had not been robust and the provider failed to adapt and intervene in a prompt manner as residents' needs changed or as safety concerns arose.

This centre has been subject to an increased level of regulatory activity since April 2022 when unsolicited information was received which raised concerns in regards to care practices, including the quality of care, complaints, safeguarding and the governance and management arrangements. In response to this concern, a provider assurance report was issued which required Ability West to complete an internal review of these concerns, including the oversight measures which were in place to keep residents safe and ensure the quality of care was maintained to a good standard. When responding to these concerns, Ability West highlighted that a 'Task Force Committee' would conduct a comprehensive review of care to monitor the changing needs of residents and future delivery of care.

In December 2022 a risk inspection was conducted as concerns were emerging in regards to oversight of centres which were operated by this provider. As part of this inspection, the actions which the provider had committed to in their provider assurance report were also reviewed. Significant issues were found on the December inspection with regard to the fire safety measures and an urgent action was issued as the provider failed to demonstrate that residents could evacuate the centre in the event of a fire. In addition, concerns were also raised with regards to fundamental aspects of care with the role of the person in charge, staffing and governance arrangements deemed not compliant. The provider had failed to implement the task force review whose aim it was to review the service and assist in the future planning of care. Considering the significance of the concerns, the provider was required to attend a warning meeting where a formal warning letter was issued to members of the board of Ability West. The warning letter stated that the Chief Inspector would consider cancelling the registration of the centre if the provider did not make improvements in the quality and safety of support for residents in the centre.

This inspection was undertaken to review care and to monitor the actions which were taken by the provider to bring this centre back into compliance with the regulations. A pivotal aspect of these actions was the task force committee review which had been finally undertaken since the warning letter was issued to the provider.The inspector read the review report and discussed it with the person in charge and with a senior manager who was on the Task Force Committee.

The Task Force had been established in January following the warning meeting with the regulator and consisted of a senior manager, the person in charge, a speech and language therapist and also a quality and compliance officer. The Task Force issued it's report in April 2023.

Inspectors found that considering the aging population of residents and their diverse needs that the scope of expertise which conducted this formal review of care was limited and failed to include a general health or age care specialist. In addition, an

inspector spoke with a senior manager on the telephone in regards to the residents' participation in this review and they confirmed that no formal consideration was given to the views of residents or their representatives in order to capture their satisfaction with the service or how they would like to see their care delivered into the future. Inspectors found that both of these issues had a significant impact on the quality of this review.

When inspectors had reviewed the task force committee's report it clearly outlined deficits in regards to access to multidisciplinary supports, provision of transport and concerns in regards to meeting the future needs of residents. Following their review, the task force made 11 recommendations in relation to the service. Inspectors spoke with the person in charge and with the senior manager who confirmed that the provider had taken no actions in response to the recommendations in the report in the five months since the completion of the report. In addition, a service improvement plan had not been developed in relation to the recommendations in the report. Inspectors found that overall, the task force review of the service had made little difference to the quality or safety of the service which residents received.

The provider had also given assurances to the chief inspector that a programme of quality improvement had commenced in services it operated which included this centre. The provider had introduced a quality enhancement plan which aimed to condense actions generated from internal audits and external reviews of the centre and monitor progress in resolving identified issues. However, inspectors reviewed the last quality audit in the centre and found that it had been completed within one hour. This review examined the actions from both the last inspection and also the organisation's own previous internal review of care but failed to undertake any further examination of services and failed to identify significant issues which were identified on this inspection. As with the task force committee review, inspectors found that internal review mechanisms and the provider's quality enhancement plan did not lead to better outcomes for residents in this centre.

Although the ceasing of respite care had resulted in some positive changes in regards to the care which full time residents received, fundamental flaws remained in regards to the oversight and governance of care. This inspection highlighted that there was a lack of urgency, on the part of the provider, in responding to an increase in falls for one resident, with significant delays with regard to multi-disciplinary reviews. Given this resident had experienced four falls since their last physiotherapy review, this had not prompted the provider to urgently provide the multi-disciplinary support required, to allow for an appropriate re-assessment of this resident's care. The absence of review had resulted in local management guiding staff on how to care for this aspect of this resident's care, without the guidance and support from the relevant allied health care professionals. As mentioned above, the provider's task force review had also highlighted these issues in regards to the allocation of multidisciplinary supports and the future delivery of care. However, the report's recommendations were not implemented by the provider, which resulted in a failure to improve the safety of this resident.

As mentioned throughout this report, residents who used this service required significant support and they depended on staff to assist them with many of their

personal, social, healthcare, nutritional and safety needs. Inspectors found that staff had a good knowledge of residents' needs. The person in charge also maintained a rota which highlighted that residents were supported by staff who were familiar to them. However, there were significant deficits in regards to the provision of staffing resources in this centre, with records showing that on a number of occasions, residents were not supported with a suitable and safe level of staff as set out in the Statement of Purpose. This included a number of incident reports reviewed by inspectors, where several staff shortages had reportedly occurred, particularly in the morning time. Considering the dependency that residents had on staff for their day-to-day care, inspectors found that this lack of consistent staff resources had the potential to negatively impact on the quality and safety of care which residents received.

## Regulation 14: Persons in charge

The role of the person in charge is pivotal in the oversight of day-to-day care. The person in charge is required to have the capacity to fulfill their duties with the appropriate implementation of this role assisting in ensuring that residents receive a service which is safe and also of good quality.

The provider clearly demonstrated that the person in charge had the capacity and capability to fulfill their duties. The person in charge also demonstrated a good understanding of the residents' needs and also of the services and supports which were in place to meet those needs.

Judgment: Compliant

## Regulation 15: Staffing

Inspectors reviewed the assessed needs of residents and other documentation and found that the Statement of Purpose reflected a safe level of staffing based on the support needs of residents. However, when inspectors reviewed the staff roster, there were regular occasions where the provider was failing to ensure that the required staffing resources were available. From reviewing the residents level of support needs, this was of particular concern in the mornings where staff needed to assist residents with personal and intimate care and support them to get ready for the day.

Judgment: Not compliant

## Regulation 16: Training and staff development

A schedule of team meetings which facilitated the staff team to raise concerns in relation to care practices was in place. The person in charge attended the centre on a regular basis and scheduled support and supervision was in place for staff.

The provider also had a schedule of mandatory and refresher training in place which assisted in ensuring that staff could care for the assessed needs of residents. A review of training records indicated that all mandatory and refresher training had been completed as recommended.

Judgment: Compliant

## Regulation 23: Governance and management

Robust oversight arrangements are fundamental to the provision of care. Inspectors found that the governance and management arrangements in this centre required significant improvements as there had been a regression in the overall quality and safety of care which residents received since this centre's last inspection. The actions which were implemented by the provider in response to the last inspection and in response to concerns raised by the Chief Inspector had not brought about sufficient change. There were continuing deficits with regards to staffing, governance and management, health and social care and risk management. Inspectors also found that the provider's own internal unannounced monitoring system for this centre was not robust in nature and failed to identify issues of concern and bring about an improvement in the care which residents were provided.

Furthermore, the provider failed to ensure that the centre was adequately resourced in line with residents assessed needs and that oversight of this centre was maintained to a good standard. In addition, recommendations which were made as part of a task force review of care were not implemented which impacted and the quality and safety of care which residents received.

Judgment: Not compliant

## **Quality and safety**

Since the last inspection, the provider had improved fire evacuation arrangements, by increasing night-time staffing arrangements, and by also conducting a number of fire drills, which demonstrated that staff could now evacuate residents in a timely manner. However on this inspection, inspectors noted a significant decline in

compliance levels since the last inspection, particularly in relation to responding to residents' assessed needs and risk management.

As previously mentioned, six residents lived in this centre, some of whom were of an aging profile, and each required a significant level of staff support with various aspects of their assessed needs. Some required manual handling support, others were identified as being at high risk of falls, on-going behavioural support was required by some, others required support at mealtimes, all had specific personal and intimate care needs, with some also having a visual impairment. Each were dependent on staff to support them with their activities of daily living and staff needed to maintain regular supervision of some residents, in order to keep them safe from identified risks. Due to the health care needs of some residents, there was also a reliance on the input of various allied health care professionals to inform the type of care they received.

Given that the residents were aging and the level of their support needs, they were experiencing changes in their support needs, sometimes over a short period of time. The provider was failing to ensure that they were monitoring these changing needs and were responding in a timely manner to ensure the safety of residents. Inspectors could see that staff locally were very kind and supportive of residents and were trying to respond to the changing needs of residents, but the provider was failing to recognise the need for different resources to support staff to care for residents appropriately, even though they had commissioned an internal Task Force Review, which had highlighted this requirement. Inspectors noted that the provider had developed a new risk management escalation pathway but found that the new arrangements were not effective and that the provider's own monitoring of their services had failed to identify this. This is discussed further under Risk Management below.

Where incidents occurred, these were recorded by staff and reviewed routinely by the person in charge and team leader. As part of the provider's risk management system, in recent months a new escalation pathway was developed, to allow local management to bring high-rated risks relating to the centre, to the attention of the provider to review on a monthly basis. The person in charge had used this system to make the provider's aware of, specific risks relating to this centre, in relation to staffing resources and falls risks. Although this system of referral to the provider had the potential to promote the safety of care, there was a lack of urgency on the part of the provider, to act upon the information provided to them as part of this new system, to urgently respond to, the significant risks posed to the provision of care in this centre, due the lack of multidisciplinary support and adequate staffing resources for residents. Furthermore, despite these risks being escalated by local management, once submitted, there was poor correspondence from the provider, to local management, in relation to any planned response towards addressing these issues.

Although within the aforementioned compliance and quality improvement plans, the provider had recognised the need for significant changes to be made to the overall risk management system, and to the arrangements in place for residents' assessed needs, this had little impact on their response to specific risks that were occurring in

this centre. Instead of progress towards improvement, upon this inspection, inspectors found an overall decline in both these aspects of service, since the last inspection. The failure of the provider to provide timely multi-disciplinary supports had the potential to impact the quality and safety of care of residents, as the care they received was not informed by an appropriate re-assessment of their needs. Identified risks, despite escalated, were not responded to, appropriately monitored, or addressed by the provider, in such a manner that assured the Chief Inspector the provider was taking appropriate action to manage specific risks, so as to better, and make safer, the care that these six residents received.

## Regulation 12: Personal possessions

The provider had ensured that a system was in place in this centre to support each resident to access their finances. This was regularly monitored by the person in charge, who ensured daily checks and balances of residents' accounts were completed. Equally, effective oversight was also maintained of the recording of all lodgements and transactions to residents' accounts. During their engagement with the inspectors, the team leader demonstrated very clear understanding of the management and safeguarding of residents' finances and ensured this was regularly discussed with staff members on an on-going basis.

Judgment: Compliant

## Regulation 13: General welfare and development

The provider had ensured that each resident was provided with the support they required, to get out and about to enjoy a variety of activities. Each resident required a certain level of staff support to engaged in social activities, and this was provided to them. From the records reviewed by inspectors, these clearly evidenced the level of social activities and engagement that these residents were provided with. For those who responded well to more sensory based activities, staff ensured these were occurring for these residents. Along with regularly attending day services, residents were consulted on what activities they wanted to engage in evening times and weekends, with in-house activities also provided to residents, if they wished to take part.

Judgment: Compliant

## Regulation 26: Risk management procedures

The provider had a system for recording and responding to incidents and a review of associated records indicated that some individual incidents had been promptly reviewed by management of the centre, particularly in relation to medication management. However, other incidents which had occurred relating to staff shortages and falls management, had not been addressed by the provider in the same manner.

The provider was failing to recognise the urgency in ensuring regular and timely reviews of risks to the healthcare of residents. For example, inspectors reviewed the records of one elderly resident who had been experiencing an increased number of falls since their previous physiotherapist appointment in July 2023, with one incident requiring them to be brought to Accident and Emergency Department for treatment. While local staff were taking actions to try to keep the resident safe, the provider had failed to ensure the necessary multi-disciplinary support required by this resident, were made available to ensure a full re-assessment of this resident's falls risk assessment.

Furthermore, in response to a number of incidents where the centre experienced times of staff shortages, the provider had also not responded to, and addressed this increased risk to service provision. These staff shortages were occurring primarily in the morning, posing a potential risk to the sustainability of the quality and safety of this service, as all six residents required care and support with their mobility needs, personal and intimate care at this time.

Inspectors reviewed the overall risk management arrangements in the centre. Each centre within the organisation was required to identify their top five risks, to risk rate them and to submit them to senior management. While the inspectors saw the risks that had been submitted, there had been no response from management to confirm that the control measures were appropriate, or to provide feedback on the quality of risk management. In addition, inspectors identified potential risks during the inspection, relating to multi-disciplinary support, which had not been identified by the provider, had not been risk-rated and control measures implemented. There was no evidence that the provider's new risk management arrangements were being used to inform actions to improve the safety of residents.

Judgment: Not compliant

## Regulation 28: Fire precautions

Since the last inspection of this centre in December 2022, the provider had put measures in place to improve the evacuation of residents from this centre, particularly at night. Additional training was provided to staff, increased night-time staffing arrangements were put in place and multiple fire drills had been undertaken. A record of these fire drills were reviewed, which identified a marked improvement in staffs' ability to ensure timely evacuation of residents from this

centre. The provider had also engaged with local fire services, who attended the centre to meet with residents and familiarise them with the equipment that would be used by emergency services, in the event of a fire. In addition to this, the provider had plans in place to conduct a further fire drill, with members of the fire service present, in the coming weeks.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

The provider had procedures in place for the prescribing, administration and storage of medicines. In response to a number of medication errors which had occurred in the months prior to this inspection, the provider put additional measures in place, which had been effective in reducing similar errors from re-occurring. This aspect of the service was also subject to regular auditing and on-going support was provided to staff, as and when required.

Although the administration of as-required medicines was rare in this centre, there were some improvements required to this aspect of this centre's medication management. For instance, although a recent multi-disciplinary review of a chemical restraint protocol, led to a change in the medication to be administered, this was not yet prescribed on the resident's prescription kardex. Furthermore, where as-required pain relief was prescribed for residents, some of these required review to ensure clarity was provided to staff, where there may be contraindications between residents' prescribed regular medicines and their as-required prescribed medicines. In addition, improvement was also required to ensure prescription kardexs clearly detailed the indication for use and maximum dose to be administered, for as-required medicines. These improvements were brought to the attention of those facilitating the inspection who made progress before close of the day to have these issues addressed.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Inspectors reviewed the residents' records and found that each resident did have an assessment of need relating to their social, personal and healthcare support needs. However, inspectors found that these were not being reviewed in a timely manner when residents' needs were changing. This was particularly concerning when considering the level of support that these residents required and their changing needs. For example, as discussed earlier, one resident had experienced an increased number of falls which were a significant risk to their safety, and the provider had

failed to respond appropriately to re-assess the needs of that resident.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

The provider had ensured staff were supported by multi-disciplinary input, in the care and support of residents' who had assessed behavioural support needs. Where behavioural related incidents occurred, these were reviewed and residents' behaviour support plans were updated, with clear interventions to be implemented by staff, as and when required.

Although restrictive practices were maintained under regular review, this inspection did identify where some improvements were required. For instance, during a walk-around of this centre, inspectors observed two practices, which the provider had not considered reviewing, in line the centre's restrictive practice policy. These practices related to the restricted use of a television remote and restricted access to the centre's laundry room. Furthermore, although the use of chemical restraint in this centre was rare, this inspection did identify where a review of a resident's restrictive practice protocol for the use of this type of restraint was required, to give better clarity to staff on what specific behaviours would need to be observed, in order to warrant administration, to ensure it was only ever administered, as a last resort.

Judgment: Substantially compliant

## Regulation 8: Protection

The provider had safeguarding procedures in place, to guide staff on the identification, reporting, response and monitoring of any concerns relating to the safety and welfare of residents. All staff had up-to-date training in safeguarding and there was a designated officer allocated to this centre, to review any safeguarding concerns. In response to a previous incident, there was an on-going safeguarding plan in place, which up to the time of inspection, had been effective in preventing a similar safeguarding incident from re-occurring.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Not compliant |
| **Quality and safety** | |
| Regulation 12: Personal possessions | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for St Dominic's Services OSV-0001507

## Inspection ID: MON-0041321

## Date of inspection: 18/10/2023

**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>• There are three staff on duty during waking hours (mornings and evenings) and there continues to be two staff on duty at nighttime (this remains unchanged; one waking night and one sleepover staff). This is to ensure sufficient staffing to meet the assessed support and supervision needs of all residents.<br>• A care assistant has commenced in post in St Dominics Services on 1st December 2023.<br>• A Social Care worker has been appointed and will commence on 22nd January 2024<br>• There is an agency social worker currently working in the service and they will remain in the post until 22nd January 2024<br>• The staff roster was reviewed and updated so that it now accurately reflect the hours worked by all staff, including night duty shift.<br>• A Person in charge with responsibility only for St Dominics Service has been appointed and their hours are reflected in the roster<br>• We continue to work with staffing agencies to provide staff cover where there is a need in the roster<br>• Recruitment is ongoing in the area to recruit relief staff to work in the services. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• The Provider has appointed a Person in charge on a full-time capacity with responsibility only for St Dominics Service. The person in charge will be supernumerary | |

to rostered shifts to ensure capacity to fulfil supervision, management, administration, and governance responsibilities across the designated centre. Completed 27th November 2023
• There are three staff on duty during waking hours ( mornings and evenings) and there continues to be two staff on duty at nighttime (this remains unchanged; one waking night and one sleepover staff). This is to ensure sufficient staffing to meet the assessed support and supervision needs of all residents.
• A care assistant has commenced in post in St Dominics Services on 1st December 2023.
• A Social Care worker has been appointed and will commence on 22nd January 2024
• There is an agency social worker currently working in the service and they will remain in the post until 22nd January 2024
• The Person in Charge of the Centre has carried out a full review of the designated centre risk assessments and the risk register has been updated to reflect all risks within the Centre and risk rated accordingly.
• The Person in Charge will review the centre risk register monthly, or more frequently where evidence of increased risk or other changes arises.
• The Person in charge will review all incidents as and when they occur to identify trends, evidence or other indicators that a review of risk or resident's needs assessment is required.
• The risk register will be reviewed monthly or more frequently if additional risks are identified within the house.
• The Area Services Manager will review the risk register monthly with the person in charge and ensure that effective control measures are in place. If warranted the person in charge will escalate a risk to the Area Services Manager.
• If warranted the Area Services Manager will escalate a risk to the Director of Operational Supports and Services.
• Where a risk cannot be safely addressed within the service the Director of Operational Supports and Services will escalate the risk to the Corporate Risk Register via the Senior Management Team.
• The assessment of needs have been reviewed and updated for all residents by the Person in Charge.
• The person in charge is responsible for ensuring that residents' assessments of needs are up to date and accurate.
• The Area Services Manager will audit resident needs assessments on a monthly basis and escalate if evidenced a need to review staffing arrangements in St Dominics service.
• The Person in charge will review all incidents as and when they occur to identify trends, evidence or other indicators that a review of risk or resident's needs assessment is required.
• Staff meetings, facilitated by the person in charge, are held weekly. Standing agenda items include review of incidents, risk register and management and changing needs of residents.
• Where there is identified and immediate change needs for the residents, the residents changing needs will be highlighted via the complex case pathway and escalated to the Director of Clinical supports and services. There is a clear pathway in place for Complex cases referrals and all person in charge have been trained on this.
• A new system for the management and prioritization of referrals to the multi-disciplinary team has been implemented effective from Monday 4th December 2023. This will centralize all MDT referrals and enable the prioritization of MDT support for

residents. There is a clear pathway in place for MDT referrals going forward and all people in charge have been trained on this.
• Ability West are actively recruiting nursing supports to meet the changing needs of our residents across our residential services. A business case has been submitted for additional nursing support to the HSE. We have a nurse recruited who will be commencing in post on 8th January 2024 and will be providing nursing support to our residents across the region.
• The task force process has been ceased and this has been replaced with the following approach:
• The Support Needs Assessment for all the residents has been completed by the person in charge and the multi-disciplinary team. The Director of Clinical Supports and Services has led this Support Needs Assessment. The Support Needs Assessment will inform the current and future needs for each resident in St Dominics. Completed October 2023.
• As a follow on from the completion of the support needs assessment, future planning meetings for all the residents in St Dominics will be held by the person in charge, keyworker with the individual resident and input from the family. This is to be completed by 31st January 2024.
• An audit tool and audit schedule has been implemented in the centre and is part of the monthly service review with the Area Service Manager. The person in charge is responsible for the completion of the audits in line with the audit schedule.
• The Director of Operational Supports and Services will meet with the Area Service Manager and the Person in Charge on a quarterly basis in the designated centre to complete a service review and audit.
• The provider led audit process and template has been updated and will be completed by 31st December 2023 .

| Regulation 26: Risk management procedures | Not Compliant |
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in charge attended a risk management workshop on 10th November 2023.
• The Person in Charge of the Centre has carried out a full review of the designated centre risk assessments and the risk register has been updated to reflect all risks within the Centre and risk rated accordingly.
• The Person in Charge will review the centre risk register monthly, or more frequently where evidence of increased risk or other changes arises.
• The Person in charge will review all incidents as and when they occur to identify trends, evidence or other indicators that a review of risk or resident's needs assessment is required.
• The risk register will be reviewed monthly or more frequently if additional risks are identified within the house.
• The Area Services Manager will review the risk register monthly with the person in charge and ensure that effective control measures are in place. If warranted the person

in charge will escalate a risk to the Area Services Manager.
• If warranted the Area Services Manager will escalate a risk to the Director of Operational Supports and Services.
• Where a risk cannot be safely addressed within the service the Director of Operational Supports and Services will escalate the risk to the Corporate Risk Register via the Senior Management Team.
• Staff meetings, facilitated by the Person in Charge, are now held weekly. Standing agenda items include review of incidents, risk register and management and changing needs of residents.
• The Area Services Manager will review the risk register with the Person in Charge monthly at service reviews carried out within the Centre.
• The process of submitting the top five risk monthly has been replaced with the risk escalation pathway in line with the risk management policy and procedure.
• There are three staff on duty during waking hours (mornings and evenings) and there continues to be two staff on duty at nighttime (this remains unchanged; one waking night and one sleepover staff). This is to ensure sufficient staffing to meet the assessed support and supervision needs of all residents.
• A care assistant has commenced in post in St Dominics Services on 1st December 2023.
• A Social Care worker has been appointed and will commence on 22nd January 2024
• There is an agency social worker currently working in the service and they will remain in the post until 22nd January 2024
• A new system for the management and prioritization of referrals to the multi-disciplinary team has been implemented effective from Monday 4th December 2023 . This will centralize all MDT referrals and enable the prioritization of MDT support for residents.
• The Director of Operational Supports and Services will meet with the Area Service Manager and the Person in Charge on a quarterly basis in the designated centre to complete a service review and audit which will include a review of the risk register

| Regulation 29: Medicines and pharmaceutical services | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All medication Kardex's have been reviewed by the GP. Completed on 7th November 2023
• All staff have been retrained on the medication policy and procedure. Completed on 5th September 2023.
• Staff meetings, facilitated by the Person in Charge, are held weekly.
Standing agenda items include review of incidents, risk register, medication management and review of any incidents/errors in the prior month.

| Regulation 5: Individual assessment and personal plan | Not Compliant |
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

- The assessment of needs have been reviewed and updated for all residents by the Person in Charge.
- The person in charge is responsible for ensuring that residents' assessments of needs are up to date and accurate.
- The Area Services Manager will audit resident needs assessments on a monthly basis and escalate if evidenced a need to review staffing arrangements in St Dominics service
- The Person in charge will review all incidents as and when they occur to identify trends, evidence, or other indicators that a review of risk or resident's needs assessment is required.
- Staff meetings, facilitated by the person in charge, are held weekly. Standing agenda items include review of incidents, risk register and management and changing needs of residents.
- Where there is identified and immediate change needs for the residents, the residents changing needs will be highlighted via the complex case pathway and escalated to the Director of Clinical supports and services. There is a clear pathway in place for Complex cases referrals and all person in charge have been trained on this.
- A new system for the management and prioritization of referrals to the multi-disciplinary team has been implemented effective from Monday 4th December 2023. This will centralize all MDT referrals and enable the prioritization of MDT support for residents. There is a clear pathway in place for MDT referrals going forward and all person in charge have been trained on this.
- Ability West are actively recruiting nursing supports to meet the changing needs of our residents across our residential services. A business case has been submitted for additional nursing support to the HSE. We have a nurse recruited who will be commencing in post on 8th January 2024 and will be providing nursing support to our residents across the region.
- The task force process has been ceased and this has been replaced with the following approach:
- The Support Needs Assessment for all the residents has been completed by the person in charge and the multi-disciplinary team. The Director of Clinical Supports and Services has led this Support Needs Assessment. The Support Needs Assessment will inform the current and future needs for each resident in St Dominics. Completed October 2023.
- As a follow on from the completion of the support needs assessment, future planning meetings for all the residents in St Dominics will be held by the person in charge , keyworker with the individual resident and input from the family . This is to be completed by 31st January 2024 .

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| Regulation 7: Positive behavioural support | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• The restriction in relation to the remote control for one Resident is no longer in use.
• A restrictive practice relating to a door handle has been referred to the restrictive practices committee for review and is evident on restrictive practice logs within the Centre.
• An environmental review was carried out within the Centre between the Person in Charge and the Area Services Manager to ensure effective oversight of all restrictions within the Centre. Completed 21st November 2023
• The Behavioral Support plan and the PRN Protocol have been reviewed in conjunction with the Behavioral Support Manager and the Residents Psychiatrist to ensure clear guidance for the staff team. Completed 21st November 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 |
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| 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. | Not Compliant | Orange | 01/12/2023 |
| 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. | Not Compliant | Orange | 01/12/2023 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in | Not Compliant | Orange | 01/12/2023 |

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| | place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. | Not Compliant | Orange | 31/12/2023 |
| 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. | Not Compliant | Orange | 04/12/2023 |
| Regulation | The person in | Substantially | Yellow | 07/11/2023 |

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| 29(4)(a) | charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely. | Compliant | | |
| Regulation 05(1)(b) | The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis. | Not Compliant | Orange | 01/12/2023 |
| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and | Substantially Compliant | Yellow | 21/11/2023 |

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| | evidence based practice. | | | |