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 Rita's Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	13 March 2024
Centre ID:	OSV-0003915
Fieldwork ID:	MON-0042291

About the designated centre

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

St Rita's Residential Service can support four male and female adults, with intellectual disability and or autism as well as additional physical and or sensory disability. Residents supported at the service range in age from 18 years upwards. The centre comprises of a purpose built house in a rural town. Residents are supported by a staff team that includes the person in charge, social care workers and social care assistants. Staff are based in the centre when residents are present, including at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 13 March 2024	10:00hrs to 17:20hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This centre is run by Western Care Association in Co. Mayo. Due to concerns about the governance and oversight of Western Care Association centres and its impact on the wellbeing and safety of residents, the Chief Inspector of Social Services undertook a targeted safeguarding inspection programme which took place over two weeks in March 2023 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection), regulation 23 (Governance and management) and regulation 26 (Risk management procedures). The overview report of this review has been published on the Health Information and Quality Authority (HIQA) website. In response to the findings of this review, Western Care Association submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, but also to assess whether the actions of Western Care Association have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Mayo. At the time of the inspection the provider had completed a number of actions while others had been commenced and were in progress. The governance arrangements had been strengthened through the assessment of senior and frontline management structures. Service areas had been reconfigured.

In this centre, residents were supported to engage in activities that they enjoyed. Staffing arrangements meant that the personal and social needs of residents were addressed. However, improvement was required in relation to the oversight of the service, staff training, the supports for residents to manage their behaviour and the promotion of residents' rights.

The centre was a large, single-storey building in a town. It was near shops, hotels and local amenities. Each resident had their own bedroom. Two bedrooms had tracking hoists in the ceiling. Three bedrooms had an en-suite bathroom. The fourth bedroom had direct access to the large main bathroom. This bathroom could also be used by other residents. All bathrooms had level access showers. The centre also had a large kitchen-dining room and a separate sitting room. There was a large utility room next to the kitchen. In addition, the centre had a staff office, a store room, and a staff sleepover bedroom with en-suite bathroom. Outside, the residents had access to a large garden to the rear of the house.

The centre was clean, tidy and in good repair. The person in charge reported that the sitting room had recently be repainted and that the curtains had been changed. Residents' bedrooms were decorated in different styles and personalised with their photographs and belongings. Residents had adequate storage for their clothing and personal items. However, the inspector noted that the wardrobe in one resident's bedroom was locked. It stored archived files and paperwork relating to the resident and the resident did not have a key for this wardrobe. The person in charge reported that the paperwork was stored in the resident's room as there was no

other storage for archived paperwork in the centre. They also reported that the resident's bedroom was not fit for purpose as it was too small to meet the needs of the resident. The en-suite bathroom for this bedroom was small and the person in charge reported that it could no longer be used by the resident. The resident now showered in the shared bathroom in the centre. This will be discussed later in the report.

The inspector met and spoke to two of the four residents. The residents used nonspeaking methods to communicate. The other two residents returned to the centre later in the day but were unavailable to meet the inspector. Residents spent time relaxing in the sitting room of the centre. They were supported to leave the centre during the day to engage in activities in the community that they enjoyed. Other residents were supported to attend day services and medical appointments.

Staff spoke about residents in a respectful manner. They were knowledgeable on the needs of residents. Staff described some of the specific supports required by residents in relation to their daily lives. Staff spoke about the ways that they prepared food to the consistency required by residents and were observed preparing the midday meal for residents. They spoke about the supports they offered residents to manage their behaviour. They were knowledgeable of the steps that should be taken should a safeguarding incident occur. Staff reported that they had received adequate training to support residents. Staff had not received specific training in human rights-based care.

Overall, residents were supported to engage in activities within the centre and the wider community. However, improvement was needed in relation to the auditing arrangements in the centre, staff training, risk management, positive behaviour support and residents' rights. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

The provider had clear lines of accountability in this service. Staffing numbers and skill-mix were suited to the needs of residents. However, improvement was required in relation to staff training and the oversight of the service.

The management structure was clearly defined. The centre had an assistant manager to support the person in charge. Senior management structures were also clearly outlined. Staff knew who to contact if an issue arose and how to report incidents. However, there was no roster of out-of-hours management cover. There was a system whereby managers were listed by hierarchy and staff were directed to begin by contacting the person in charge. If the person in charge was unavailable, staff were directed to continue to the next level of management until they received a response. This meant that managers were effectively on-call at all time and that

the director of operations had to be contactable at all times. This system was not sufficiently robust to ensure that staff could escalate any incidents or emergencies when they arose and receive a response in a timely manner.

The provider maintained oversight of the service through incident reviews and audits. Incidents in the centre were reviewed every three months. Any trends were identified and information was shared with staff at team meetings to avoid reoccurrence. However, improvement was required in relation to the auditing system in the centre. The provider had identified a number of audits that were due to be completed on a monthly basis. A review of these audits found that they were not always completed in line with the provider's schedule. For example, there was no record of a financial audit or audit of the residents' individual plans having been completed in 2024. In addition, the audit tools were limited, generic and not reflective of the needs of residents or the service. The audits had not been reviewed or updated since the targeted inspection that had been completed 12 months previously. Issues in relation to risk management and restrictive practice that were noted on inspection had not been detected on audit. This will discussed later in the report.

The information that was gathered on audit was not always useful to identify areas for service improvement. There was evidence that issues were noted on numerous audits but had not been addressed by the provider. For example, every medication audit completed between January 2023 and March 2024 had identified that staff required training in the same five specific areas. However, training in these modules had not been arranged and the issue of repeated findings on audit had not been addressed by the provider. In addition, the provider had completed an unannounced audit of the centre in November 2023. The report from this audit included a review of the centre's monthly audits. However, this report had not identified the issues outlined above.

The staffing arrangements were suited to the needs of residents. The number of staff on duty was appropriate to ensure that residents were supported with their care needs and their activities in the wider community. However, improvement was required in relation to staff training. The provider had identified a number of training modules for staff. The person in charge reported that a training needs analysis had been completed and, where staff required training, a request had been submitted for staff to avail of training sessions when they were run by the provider. However, no specific dates for training had been identified. In addition, it was noted that a large number of staff required training in certain modules. For example, 11 staff required training in the theory module of feeding, eating, drinking and swallowing (FEDS) and 10 required training in the FEDS competency module. In addition, the five training areas noted on the medication audit were not included in the training needs analysis. The six-monthly unannounced audit noted that staff required training in 'skin integrity', yet this was not included on the training schedule.

Overall, staffing arrangements were suitable to meet the residents' assessed needs. However, improvement was required in relation to the auditing and oversight systems in the centre and staff training.

Regulation 15: Staffing

The number and skill-mix of staff was suited to the needs of residents. The team were consistent and familiar to the residents. There was a planned and actual staff rota.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified a number of training modules for staff. Where staff required training, their names were forwarded to the provider's training department so that they could be listed for upcoming training modules. However, it was noted that a significant number of staff required training in certain areas. For example, 11 staff needed training in the theory module for managing FEDS. In addition, specific dates for any of these training modules had not been identified. Further, the training needs identified on the provider's six-monthly unannounced audit had not been included in the training needs analysis.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 12 actions aimed at improving governance arrangements at the centre. The provider aimed to have all actions completed by 31 January 2024. At the time of the inspection, six actions had been implemented with the remainder in progress.

Completed actions included:

- a review of senior management structure
- a reconfiguration of service areas
- the development of a service improvement team
- scheduling of six-monthly unannounced audits of centres and allocating a manager from outside of the region to complete these audits
- the re-establishment of an incident review committee
- the development of a standardised monthly reporting template

The six actions that were in progress can be summarised as follows:

- The assessment and review of frontline staff was ongoing and on-call arrangements had not been addressed in this centre
- The review of audits was ongoing. A new template for the six-monthly unannounced visits had been devised. However, a review of audits used within centres had not been commenced.
- The new training system was piloted in two areas but not yet rolled out across the organisation
- Most staff had attended regulatory information events with 18 staff yet to attend.
- The provider had completed the final draft of the policy and procedure framework but this had not yet been circulated to staff.
- The Human Rights Committee had not yet been fully established. An interim rights chairperson had been identified.

In this centre, the lines of management were clearly defined. Staff knew who to contact to escalate any issues that might arise. However, the auditing procedures and oversight of the service required improvement. Audits were not always completed in line with the provider's timeline. In addition, audits were not specific to the needs of residents and the service. They were not always adequate to identify areas for service improvement. Where areas for service improvement were identified, this was not always addressed by the provider.

Judgment: Substantially compliant

Quality and safety

The health and social care needs of residents in this centre were identified and supports were in place to enable residents engage in daily activities in the centre and the wider community. However, improvement was required in relation to the premises, the review of restrictive practices, the promotion of human rights and risk management arrangements.

As outlined above, the centre was in a good state of repair and, overall, suited to the needs of residents. The centre was accessible and equipped with the necessary facilities to meet the needs of residents. For example, two bedrooms were fitted with tracking hoists. However, one bedroom had been identified as inappropriate to the needs of one resident as it was too small. Minutes from staff meetings and emails to members of senior management indicated that this was a long-standing issue but, on the day of inspection, there were no plans to address the issue.

The health and social care needs of residents were well managed. An assessment of the needs of residents was completed annually. The supports required by residents to meet those needs were outlined in the residents' individual plans. These documents were updated frequently. A personal plan was developed for residents and this was reviewed annually with input from the multidisciplinary team and a

family representative of the resident. Personal goals for the resident were developed.

There was evidence that the healthcare needs of residents were well-managed. Residents had access to a variety of healthcare professionals. Residents were supported to attend appointments. There was evidence that staff followed-up on referrals to healthcare professionals.

The provider had systems in place to ensure that residents were safe. This included the development of personal and intimate care plans and the inclusion of safeguarding as a standing agenda item on team meetings. Staff were knowledgeable on the steps that should be taken should a safeguarding incident arise. All staff had completed online safeguarding training. However, the face-to-face safeguarding training outlined in the provider's compliance plan had yet to be provided to staff in this centre.

Improvement was required in relation to the arrangements for positive behaviour support in the centre. Where residents required support to manage their behaviour, guidance for staff was available in the form of individual risk assessments. Staff were knowledgeable on the content of these risk assessments. However, these assessments were completed by staff within the centre and had not been reviewed by an appropriate healthcare professional. Two residents who were at risk of self-injurious behaviours had not been referred to the behaviour support service. In addition, nine staff required training in managing behaviour that is challenging. The names of staff who required training had been submitted to the provider but, on the day of inspection, there were no definite dates identified for this training.

There were a number of restrictive practices in this centre. Significant improvement was required in relation to the review and monitoring of these restrictions. The provider had not taken adequate measures to ensure that the least restrictive option was implemented for the shortest duration of time. The restrictive practices had not been reviewed by an external rights review committee. The restrictive practice log in the centre had not been reviewed in line with the provider's timeline. The times when restrictive practices were used were not always recorded. For example, an audio-visual monitoring system was used nightly for a resident but there was no record of the times that this monitor was used. Further, the provider had failed to identify certain practices as restrictive. As outlined above, there was a locked wardrobe in a resident's bedroom. This had not been identified as a restrictive practice.

The promotion of residents' rights required improvement. Staff routinely offered choices to residents in their daily activities. They were knowledgeable on the ways that residents indicated their likes and dislikes. However, some practices in the centre impacted on the rights of residents. For example, staff completed and recorded hourly checks on residents throughout the night. This practice had not been identified as impacting on the privacy of residents and no clear rationale for the checks was provided. In addition, it was not always clearly documented that residents had been supported to consent to decisions about their life. For example, there were plans to support a resident to make a significant purchase but adequate

additional supports to assist the resident understand this decision had not been implemented.

The provider had implemented risk management procedures in the centre. The centre's risk register outlined the risks to the overall service. The risks in this register were due to be reviewed and updated quarterly. However, it was noted that the risks relating to service provision had not been updated in seven months. Individual risk assessments were completed for residents. These were reviewed regularly. However, not all risks identified on inspection had a corresponding risk assessment. For example, the risk to a resident's wellbeing due to noise and the vocalisations of other residents was not recorded, yet staff identified this as a significant issue for this resident.

Overall, residents' health and social needs were well managed. Residents were supported to engage in activities in line with their interests. However, improvement was required in relation to the supports for residents to manage their behaviour and the review of restrictive practices in the centre. Improvement was also required in relation to the promotion of human rights and the systems to manage risk.

Regulation 17: Premises

The centre was in a good state of repair. It was accessible to all residents. Equipment that was required by residents to support their assessed needs was available. However, it had been identified that one bedroom was not appropriate to the needs of one resident as it was too small. The provider did not have a plan in place to address this issue.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete three actions aimed at improving governance arrangements at the centre . The provider aimed to have all actions complete by 31 October 2023. At the time of the inspection, one action had been completed and two had commenced and were in progress.

The action that had been completed was:

- incidents were reviewed on a quarterly basis by an incident review committee.

The actions that were in progress were:

- training in incident management had been delivered to senior managers but had not been rolled out to staff in the designated centres
- the risk management policy had not been finalised

In this centre, improvement was required in relation to the systems in place to identify and manage risk. The risk assessments relating to service provision in the centre's risk register had not been reviewed since August 2023. The provider's guidelines were that these risks should be reviewed on a quarterly basis. The provider did not have a timebound plan to address the risk of the unsuitability of the premises to meet the needs of residents. The inspector noted that not all risks identified on inspection had a corresponding risk assessment. For example,

- a risk assessment had not been completed in relation to the impact on one resident due to the vocalisations of their peers. Staff reported that the resident would stop eating a meal or remain in their room if there was too much noise in the house.
- a risk assessment had not been completed to outline the reasons for hourly night time checks on residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The health and social needs of residents were assessed. These assessments were reviewed annually. Where a need was identified, there was corresponding documentation to guide staff on how to support residents. Residents had a personal plan and these were reviewed annually.

Judgment: Compliant

Regulation 6: Health care

The health needs of residents were well managed. Residents had access to healthcare and medical professionals. Residents were supported to attend appointments. There was evidence that staff followed-up on referrals.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements at the centre . The provider aimed to have all actions complete by 30 June 2024. At the time of the inspection, four action had been completed and three were in progress.

The completed actions included:

- an interim head of clinical and community support had been appointed
- additional multidisciplinary team practitioners had been employed
- a critical response team was established to review the placement of residents when required
- a behaviour oversight committee was re-established

The actions that were in progress included:

- the policy on the role of psychology and interdisciplinary team working was in draft form
- the training modules on neurodiversity were being finalised and training to managers was due to commence on 29 February 2024
- the access to appropriate multidisciplinary team supports was ongoing, for example, the standardised template for behaviour support plans had not yet been introduced.

In this centre, significant improvement was required to support residents manage their behaviour. The multidisciplinary supports required by residents in relation to positive behaviour support had not been put in place. It was not clear that restrictive practices in the centre were the least restrictive and in use for the shortest duration of time. The issues identified on inspection included:

- residents who had been identified as at risk of self-injurious behaviour had not been referred to the provider's behaviour support service or to an appropriate healthcare professional.
- there were a number of restrictive practices in the centre and these had not been reviewed by an external rights committee.
- the restrictive practice log had not been reviewed in line with the provider's timeline
- there was no record of the times and dates when an audio-visual monitor was used with one resident.
- the provider had not identified all restrictive practices in the centre, for example, a locked wardrobe in a resident's bedroom.
- nine staff required training in managing behaviour that is challenging

Judgment: Not compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving governance arrangements at the centre . The provider aimed to have all actions complete by 31 October 2023. At the time of the inspection, three actions had been completed and two were in progress.

The completed actions included:

- a new system was in place to improve staff awareness of the safeguarding process. The person in charge reported that safeguarding was the first item discussed at all team meetings and included in all supervision sessions.
- active safeguarding plans were reviewed on a quarterly basis
- a safeguarding oversight committee had been established

The actions in progress included:

- the safeguarding policy was in review
- face-to-face training in safeguarding had not been rolled out to all staff, including the staff working in this centre.

In this centre, all staff had completed online safeguarding training. Staff were knowledgeable on the steps that should be taken should a safeguarding incident arise. Incidents were recorded and reviewed. There were no open safeguarding plans in the centre on the day of inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were offered choices in this centre in their daily lives and activities. Staff were familiar with the residents' communication strategies. However, it was not clear that residents were always supported to consent to decision about their lives and care. For example, adequate additional supports had not been identified for a resident in relation to decisions about a significant purchase that was planned. The practice of checking on residents during the night on an hourly basis had not been identified as institutional and impacting on the privacy of residents. There was no documented rationale for this practice and staff were unclear of its purpose.

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Rita's Residential Service OSV-0003915

Inspection ID: MON-0042291

Date of inspection: 13/03/2024

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC will ensure that all staff complete the human rights-based approach in health and social care services. -All staff completed training as of 08.05.24 on HSEland • The PIC will nominate all staff in the centre for face to face safeguarding training. -All staff enrolled for upcoming events taking place in May and June as of 08.05.24 • The PIC will ensure all new staff completes the FEDS theory Module as part of the service induction and that the FEDS competency module is also completed by all centre staff. Bespoke training organized for the team for 24.05.24 • The PIC will nominate relevant centre staff for training in Managing Behaviours of Concern. All remaining staff enrolled in course as of 08.05.24 • The PIC will ensure that the training needs analysis for the service is updated to reflect all identified training needs of the centre. Complete 02.04.24 • The PIC will nominate all centre staff to attend the HIQA Regulatory event. • Guidance received from Public Health Nurse re Skin Integrity training who advised training was not needed for all staff, but shared guidance and literature on signs of infection which will be disseminated to staff at meeting on 24.05.24 to ensure all staff recognize signs of infection Senior management informed of same.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

• The provider submitted a business case to the commissioner of services in January 2024 for funding to strengthen the current on-call arrangement. An interim arrangement is being developed with frontline managers through the Area Teams to agree an on-call rota system of managers which will be agreed and in place before 30.06.2024. • The Provider will review the quality of the organisational audits to ensure they identify all issues that need to be addressed. • The provider has commenced the roll out of a new training system to staff in the organization. A pilot of this online system has begun in two areas within the organisation. All staff in these areas have been registered on this system with training events currently taking place following nominations by managers through the system. • The PIC will nominate all centre staff to attend the HIQA Regulatory event. • The Injury Management Policy training will commence in May 2024 • The Human Rights Committee held a meeting on the 25th March 2024. • The PIC will ensure that oversight of audits and their completion in line with the Providers timeline through the implementation of a monthly and quarterly checklist tool. • The PIC will ensure that audits are completed in recognition of each resident's specific needs and that identified actions will be correlated to a SMART action plan. • Where risks are identified from audits, the PIC will ensure that the risk register to reflect the risks and sent to the area manager for review and sign off on a quarterly basic or as required. Guidance received from Public Health Nurse re Skin Integrity training who advised training was not needed for all staff, but shared guidance and literature on signs of infection which will be disseminated to staff at meeting on 24.05.24 to ensure all staff recognize signs of infection Senior management informed of same.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The PIC and Area Manager will consult with the team at the next team meeting on 24.05.2024 to identify viable solutions to increase space for one resident. The PIC and Area manager will then meet with maintenaince and the head of properties and facilities on 29.05.2024 to outline outline viable solutions agreed at team meeting and any works needed to facilitate this, establish a schedule of works and agree a timeline for completion. The PIC and Area Manager will consult with key stakeholders on proposed works which may be required to facilitate this.	
Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The Risk Management Framework will be presented to the QSSI workstream for stakeholder engagement on the 07/05/2024. • A risk assessment has now been completed in relation to the impact on one resident due to the vocalisations of their peers. This includes proactive and reactive risk reduction measures to reduce the risk of the resident being unduly impacted by these vocalisations. The PIC will ensure this risk is reflected in the service risk register and the resident's Personal Risk Management Plan. • The PIC will review the rationale for the residents to have regular checks at night and complete a risk assessment for each resident. These risks will be included in the service risk register, each resident's personal risk management plans and rights review checklist. Completed as of 08.05.24, included in service risk register, individual PRMPs, and included in each persons Rights Checklist for review by the RRC, who have agreed to complete site visit before August 31st Where risks are identified from audits, the PIC will ensure that the service risk register is updated to reflect the risks and sent to the area manager for review and sign off on a quarterly basis or as required.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Neurodiversity training commenced on the 29/02/2024. • Inter Clinical Team Working Policy will be completed by the 30/06/2024. • The updated Behaviour Support Plan template will be completed by the end of April 2024. • The PIC has submitted a referral to the provider's behavioral support service for each resident identified as at risk of self-injurious behavior and this risk has been included on the service risk register and the resident's personal risk management plan.-BSS referral sent in 18.04.24, included on service risk register and also on PRMP • The PIC will identify the rationale for why resident's have regular checks at night and complete a risk assessment for each resident. These risks will be included in the service risk register, each resident's personal risk management plans and rights review checklist. • The PIC will submit updated rights review checklists to the Human Rights Committee and request a site visit from the committee to review restrictive practices in the center.-Updated and sent as of 18.04.24 to be reviewed by the RRC • The PIC will ensure that restrictive practice logs are updated to include all restrictive practices in the center and are reviewed quarterly in line with the providers' policy. Complete as of 08.05.24 • The PIC has ensured that a record is in place detailing dates and times when an audio-visual monitor is used. In place 13.03.2024	

• The PIC has identified alternative storage for archiving stored in a locked wardrobe in one resident's bedroom and this restriction is no longer in practice. Completed 13.03.2024
The PIC will ensure all staff receive training in Managing Behaviours of Concern-All staff nominated as of 08.05.2024

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC will nominate all staff in the centre for face to face safeguarding training-All staff enrolled all staff as of 08.05.24
• It is anticipated from communications from the national safeguarding team that a new portal will be introduced and a new national safeguarding policy will be released in Quarter 4, however these dates are subject to change.
• The organisational safeguarding policy is aligned to the National Safeguarding Vulnerable Persons at Risk of Abuse Policy and procedures.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will ensure that all staff complete the human rights-based approach in health and social care services.
• The PIC will submit a referral to the social work department to support on the best approach to supporting one resident around a potential significant purchase.
• The PIC will identify the rationale for why resident's have regular checks at night and complete a risk assessment for each resident. These risks will be included in the service risk register, each resident's personal risk management plans and rights review checklist.-Completed as of 08.05.24, included in service risk register, individual PRMPs, and included in each person's Rights Checklist for review by the RRC, who have set dates to complete site visit at end of July, early August
The PIC will submit updated rights review checklists to the Human Rights Committee and request a site visit from the committee to review restrictive practices in the center. Rights Checklist for review by the RRC, who agreed to complete site visit at end of July, early August

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 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	30/06/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/08/2024
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	30/06/2024

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	30/06/2024
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	30/06/2024
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 evidence based practice.	Not Compliant	Orange	17/05/2024
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Not Compliant	Orange	17/05/2024

	this Regulation all alternative measures are considered before a restrictive procedure is used.			
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.	Substantially Compliant	Yellow	30/06/2024
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/05/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional	Not Compliant	Orange	17/05/2024

	consultations and personal information.			