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:	Slieve Rua Residential & Respite Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	24 April 2024
Centre ID:	OSV-0003916
Fieldwork ID:	MON-0042301

About the designated centre

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

Slieve Rua provides a residential and respite service to 12 adults in three separate houses. This centre supports residents with low to high needs and can also facilitate residents with reduced mobility. One house is dedicated to respite and one resident uses this house for planned breaks. Two houses provide can residential care to up to five residents each. Each house in the centre is warm and comfortably furnished and residents' bedrooms are decorated with items of personal interest and photos of family and friends. The centre is located within walking distance of a small town in the West of Ireland. Some residents are offered an integrated service and some residents attend day services external to the centre. There is a staffing allocation to support residents during the day and there is a sleep in arrangement in place during night-time hours.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 24 April 2024	10:45hrs to 19:15hrs	Angela McCormack	Lead
Wednesday 24 April 2024	10:45hrs to 19:15hrs	Mary McCann	Support

What residents told us and what inspectors observed

This inspection was completed to monitor compliance with the regulations and to inform the renewal of the registration of the centre. Overall, this inspection found that residents were supported with their health and wellbeing by a dedicated staff team.

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 well-being 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 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 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 this inspection a number of actions had been implemented, with more in progress for completion. These will be discussed under each regulation later in the report.

The centre provided residential and respite care to up to 12 residents. There were three houses that comprised the centre. For the purposes of this inspection report the use of 'House 1, 2 and 3' will be used. 'House 1' provided residential care to five residents, 'house 2' provided residential care to four residents with one vacancy at the time of inspection, and 'house 3' provided respite to one resident on a number of planned nights throughout the month.

Inspectors were greeted on arrival to the centre on the morning of the inspection by the person in charge. Throughout the day inspectors got the opportunity to meet with eight residents, four in 'house 1' and four in 'house 2'. In addition, inspectors spoke with six staff across the two houses. 'House 3' was visited by inspectors but was not providing respite on that day, therefore there were no staff or residents present.

Inspectors were shown around 'house 1' by a resident and a staff member supporting them. Residents spoken with in this house were very happy with the care they received and the staff supporting them. One resident said that staff 'spoilt them'. Respectful and warm interactions were observed between residents and staff in this house. With support from staff residents spoke about their interests and activities that they enjoyed. These included; going out for dinner to a local restaurant, meeting friends, going to church and going to concerts. Within this

house residents enjoyed knitting, baking, watching their favourite television programmes, listening to music and playing games on their technological devices. There were magazines, music players and televisions available throughout the house. In addition, there were beautiful art pieces that some residents had created which were framed and hanging on the walls throughout the house.

Residents in 'house 2' were non-verbal; therefore inspectors relied on observations, communication with staff and a review of care plans to try to establish their views on the service. Observations were that residents were supported in a kind and respectful manner by staff. It was clear from observations and talking with staff that they were very familiar with residents, their communications and their needs. Staff spoken with had worked in the centre for many years and reported that they enjoyed working there. Residents appeared comfortable around staff and in their home as they were seen freely moving around the house in a relaxed manner. Residents in this house did not attend an external day service, however they were supported to do activities from their home. Residents enjoyed walks, shopping, day trips and attended music sessions throughout the week. In addition, the house had a beautiful sensory room that two residents were observed relaxing in and listening to music. As most residents required 1:1 support when out on activities, activities outside the house generally had to be planned for when three staff were on duty during day hours. It was noted in one resident's daily logs recently that they could not go out as there were only two staff on duty. This required review and is discussed later in the report.

In all three houses residents had their own bedrooms which were beautifully decorated and personalised with soft furnishings and personal effects. One resident proudly showed inspectors their bedroom and and spoke about, photographs that were on display. There were spacious communal areas available for residents to relax and receive visitors. In addition, both gardens were accessible and nicely decorated with potted plants, painted stones, shrubs, garden ornaments, solar lights and bird feeders. Inspectors were shown new flowers that 'house 2' planned to plant in the coming days. These two houses were clean, bright and homely. In general, they were well maintained; however some of the fire doors were missing the panel surrounding the lock and it was not clear that these would be effective in containing smoke.

'House 3' was unoccupied on the day of inspection. From a walkaround of the house, it was observed that work had been done since the last inspection to improve the upkeep of the house. The house was nicely painted, warm and well maintained overall. However, the garden area required improvements as the gate was broken and the outdoor area at the back required improvements to make it into a nice area to sit out.

There were easy-to-read documents and posters on display in the houses with information about advocacy, safeguarding, staff picture roster and fire evacuation notices. In addition, one house had a photographic staff roster that was located in a suitable location so that wheelchair users could see it. Residents also had access to assistive technology in line with their needs. For example; one resident had an audio recording of a family member wishing them goodnight, which was located beside

their bed and could be turned on by them by pressing a button.

One resident spoke about the residents' meetings that occurred in their house. They said that they found the meetings useful and spoke about things that were discussed at this meeting. When asked, they said that if they had any concern they would go to the person in charge. Residents spoken with all said that they enjoyed living in the centre and that they felt safe. In addition, the service had buses available to facilitate outings. Inspectors were told that the service was in the process of sourcing a new bus to replace one.

Residents met with were found to be supported with staff who were familiar to them. Many staff spoken with had worked in the centre for many years and it was clear that they knew residents' needs very well. Some staff had undertaken some of the training modules in human rights. Staff reported that it was a good refresher, as the centre promoted a rights based culture in general. It was clear that residents' choices and preferences were respected . For example; there was a plant decorated with colourful lights in the sitting room, and inspectors were informed that this was in place as one resident loved Christmas and this was designed so that they could enjoy similar lights to a Christmas tree throughout the year. In general, residents got opportunities to fulfil their interests. However, in 'house 2' it was noted that one resident could not go swimming regularly in line with their wishes as there was not enough staff on duty at times to facilitate this. Residents' needs in this house required a review to ensure that the staffing numbers met their assessed needs and that they could achieve their personal goals. This will be elaborated on throughout the report.

Overall, residents receiving residential care were found to be supported by a committed staff team and were supported to achieve good health and wellbeing.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affects the quality and safety of the service provided.

Capacity and capability

Overall, this inspection found that the service was managed by a dedicated person in charge who knew residents well. There were systems in place for monitoring the centre on an ongoing basis. However, improvements were required to achieve full compliance with the regulations. In particular, the assessment of risk and fire safety monitoring required improvements.

There was a clear governance and management arrangement in place. This included a person in charge who reported to an area manager, who was a named person participating in management (PPIM) for the centre. The person in charge facilitated the inspection and was found to be very knowledgeable about the needs of

residents.

The person in charge worked full-time and had responsibility for this centre only. A number of staff spoken with on the day of inspection had worked in the centre for several years and reported to enjoy their work. However, there were some gaps in the staffing positions which were in progress for completion. In addition, it was found that the staffing arrangements in 'house 2' did not effectively meet the needs of the residents at all times.

Staff were provided with training to ensure that they had the skills and competencies to support residents with their assessed needs. Where refresher training was due, dates had been set for these to be completed. Supervision occurred regularly and staff spoken with said that they felt well supported.

The monitoring arrangements by the person in charge included regular auditing of; incidents, infection prevention and control (IPC), finances, medication, fire safety and health and safety. Team meetings occurred regularly and provided opportunities for staff to come together and discuss and review practices.

The provider's arrangements for monitoring the centre included six monthly unannounced visits. The most recent one had been completed the previous week by a senior management team member and an area manager from another area. The report had not yet been received by the person in charge; however they confirmed that they received verbal feedback on actions required. A written report on the unannounced visit that occurred before that in May 2023, was available which had identified actions, many of which were completed. An annual review had been completed which included consultation with residents and their representatives.

In addition, the provider had made progress with a number of actions from the overview report. These will be discussed under each of the regulations.

Overall, residents were found to be well cared for and happy in their homes. However, improvements were required in the auditing and monitoring of risk and risk mitigating factors to ensure that the service was safe at all times.

Registration Regulation 5: Application for registration or renewal of registration

A complete application to renew the registration of the designated centre was completed by the provider within the time frames required.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time and was based in the centre. They had suitable qualifications and experience to manage the centre. They had responsibility for this centre only. They had a good understanding of residents' needs and it was evident that residents were familiar with them.

Judgment: Compliant

Regulation 15: Staffing

There was a rota in place that was well maintained and clear on who was working each day. However, the following was found;

- from a review of residents' records in one house, it was noted that one resident could not regularly achieve a personal goal of swimming, as there was not enough staff to take them. While efforts were made by the staff team to source a volunteer or explore other resource options, it remained that this goal was not fully achieved due to staffing issues.
- there were two staff vacancies that were required to be completed, as there was no permanent staff working in 'house 3'

A review of a sample of staff files found that all information required under Schedule 2 of the regulations were in place.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with training to ensure that they had the skills and competencies to support residents with their needs. This included training in: positive behaviour support, minimal handling, fire safety, safeguarding, medication administration, epilepsy and First Aid. Some staff were overdue refresher training in safeguarding; however dates had been set for this to be completed in the days following the inspection.

Staff received regular supervision from their line manager. Staff spoken with said that they felt well supported.

Judgment: 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 31/01/2024. At the time of the inspection nine actions had been completed with the remainder in progress.

The completed actions included the restructure and appointment of new senior management posts, unannounced provider visits by objective personnel, quarterly incident reviews through the incident monitoring and oversight committee, regular regulatory training events and the re-establishment of a human rights committee.

In addition, the person in charge spoke about a review of their role and governance structure recently, with recommendations made to put in place an assistant manager to support them in their role. They felt that this would be of benefit. In addition, the person in charge said that they are planning on attending a regulatory training event that was being held in May. They also spoke about a new one day training for new staff that was completed in the main offices, and felt this would be of benefit to new staff.

Some of the actions in progress and not yet completed included; the implementation of a staff training and development plan and a review of the current suite of audits.

Within this centre, there was a good management structure with systems in place for monitoring. However, the following was found

- there were gaps in assessment of needs documentation for residents in 'house 2' as it was not clear how the scoring system on the assessment of need template was used to determine the level of support required.
- there were gaps in progress notes about one residents' personal goal whereby progress was not reviewed every four months as set out in the timelines set by the provider. In addition, the effectiveness of the plan required further review as the plan could not be met due to staffing issues.
- there was a lack of oversight of staff training for 'house 3' as the local management team were not clear on whether the relief staff had appropriate training required when working alone and supporting residents. While it was confirmed by the end of inspection that the relief staff had completed training, this had not been monitored prior to the day of inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of incidents that occurred in the centre found that the person in charge submitted all notifications to the Chief Inspector as required under the regulations.

Judgment: Compliant

Quality and safety

Overall the service was found to provide good care and support to residents where their health and wellbeing were promoted. Improvements were required in risk management and fire safety to ensure that the service was safe and appropriately resourced at all times.

The person in charge ensured that residents' health, personal and social care needs were assessed. Care and support plans were developed, as required. Residents were supported to attend annual meetings about their care where goals for the future were identified. However, as mentioned previously the staffing arrangements in 'house 2' required review to ensure that residents could achieve their personal goals.

There were a number of restrictive practices in place in the centre, which related to health and safety concerns. An action from the last inspection by HIQA required a review of these practices to ensure that they were proportionate to the risk identified and the least restrictive option. While this had been reviewed by the local management team, these required review by the rights review committee.

There were systems in place for the management of risk, including risk assessments for identified risks relating to individual residents and a service risk register. However, on review of the centre risk register it was found that the risks evident in the centre and discussed with the person in charge had not been clearly assessed.

In summary, residents were found to be well looked after by a dedicated staff team. There were arrangements in place to regularly monitor practices by the management team. However, actions as discussed throughout this report were required to ensure that the service was safe at all times and met all residents' needs.

Regulation 17: Premises

The houses were found to be spacious, clean, bright and well maintained. Each resident had their own bedroom that was decorated in line with their preferences and personalised to their individual interests. Residents also had space to store personal belongings securely.

The communal areas in each house were bright, clean and comfortable. There were suitable laundry facilities in each house, and the kitchens had cooking equipment to enable residents to cook meals and to do baking.

The back gardens were accessible and in two houses they contained beautiful shrubs and potted plants, with garden furniture in place for residents to sit out and relax if they so wished.

However, the following was found:

- the garden area in 'house 3' required improvements with regard to its' maintenance. For example; the gate was broken.
- there was an odour in one bathroom in 'house 2' that required review.
- one resident who lived in 'house 2' who was reported to enjoy having a bath could no longer use the bath due to changing needs and this required review

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 risk management arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection one action was completed and two were in progress.

The completed action related to the ongoing quarterly reviews of incidents by the incident monitoring and oversight committee, minutes of which were available for review.

The actions relating to incident management training and a review of the risk management policy and procedure were reported to be in progress, with a trial of training completed by the provider, and further training events to occur when the policy was finalised.

Within this centre the following was found;

- changing needs of residents was reported to be the highest risk in the centre; however the risk assessment completed did not effectively identify all the risks nor include what control measures were required to reduce the risks and ensure residents were supported with their assessed needs at all times.
- the assessment of possible risks of introducing a new admission to 'house 2' had not been completed
- the risk mitigating measures to reduce risks associated with fire were not effective as there was an issue with some fire doors that had not been identified through any of the checks or audits
- the risks associated with disturbed sleep in one house had not been assessed. For example; two residents frequently got up during the night and the two staff working each night were on sleepover duty. It was found that over the month of February 2024, one resident was noted to be up at night on 17 nights.

- the use of relief staff in 'house 3' had not been identified and assessed with regard to required training and lone working

The person in charge spoke about a review of staffing that was in progress in 'House 2' with the admission of a new resident; however a full review of all residents' needs in this location was required to ensure that the numbers of staff met the assessed needs of all residents.

Judgment: Not compliant

Regulation 28: Fire precautions

The houses were equipped with fire safety measures including; signage, emergency lighting, fire fighting equipment, fire alarm panels and fire doors. Regular drills occurred and each resident had a personal emergency evacuation plan (PEEP) in place which outlined the arrangements to support them to evacuate.

However, the following was found;

- fire drill records did not adequately outline the scenarios under which evacuation took place during each drill, including the location of residents at the time. This meant that learning from fire drills could not be taken.
- the arrangements for checking and auditing the fire safety measures were not effective as inspectors found five doors across two houses that had damage to the panels surrounding the handles, which could compromise the effectiveness of the door in containing smoke. This had not been identified through any audits or checks and it was unknown how long these issues were present.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had care plans in place for identified assessed needs. Residents were supported to identify goals and priorities for the future at annual review meetings that were attended by residents and their representatives. Assessments of need were completed for residents to identify if they required low to high support. Improvements were required in the monitoring of goals and assessed needs. This is covered under Regulation 23: governance and management.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health. Residents were facilitated to access a range of allied healthcare professionals and interventions, including national screening programmes, where recommended. Where residents required support from the public health nurse system, this was found to be in place. One resident who had a recent health issue that required surgery was found to be well supported at times of their hospital stay and post surgery.

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 behaviour support arrangements at the centre. The provider aimed to have all actions completed by 30/06/2024. At the time of the inspection the provider had completed five of these actions, with the other two reported to be in progress.

Actions that had commenced included the appointment of an interim head of clinical and community support, the appointment of additional posts in psychology and behaviour support and the establishment of clinical and governance oversight committees. The person in charge spoke about, and it was noted in documentation, that a behaviour specialist was involved as a support for residents' behavioural needs.

The following was in progress for completion;

- the ‘neurodiversity’ training programme had commenced for managers, with dates set for further training with the aim to have all staff trained in this
- a new draft policy for supporting with behaviours and restrictive practices was in progress and not yet completed

In addition, within this centre the following was found;

- restrictive practices had not yet been reviewed by the rights review committee

Judgment: Substantially 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 safeguarding arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection, all actions had been implemented or were in progress.

The person in charge spoke about a meeting held in December with the designated officer to review safeguarding at the centre, minutes of which were available for review. This also reviewed body charts, which demonstrated good oversight of incidents also. In addition, the person in charge spoke about how the safeguarding statement had been updated and this was observed to be on display in the centre to support staff in understanding the safeguarding arrangements.

Within this centre it was found that safeguarding concerns were appropriately followed up in line with the procedures, and safeguarding plans implemented where required. In addition, residents had comprehensive personal and intimate care plans which outlined what supports they required and how to best do this. However, the following was found;

- face to face staff training in safeguarding vulnerable adults was due to be completed for all staff

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were consulted about the running of the centre through residents' meetings. One resident spoken with talked about these meetings and about the topics that they discussed such as making choices about activities and meals. There were a range of easy-to-read notices and a visual staff rota on display in accessible locations, which supported residents to be kept informed of relevant topics and the staffing arrangements in the house.

One resident spoke about how they had requested a new bespoke chair recently and that this was in progress to be delivered. They mentioned that it was slow to come; however it was clear through communications observed that they were kept informed of the progress of this. In addition, this resident said that their wishes were respected in the centre, and they gave an example of being supported to get their hair done whenever they chose.

Residents were also supported to practice their faith, and one resident spoken with on the day talked about how they enjoy going to the local church for a visit, and which they had done so on the day of inspection.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Slieve Rua Residential & Respite Services OSV-0003916

Inspection ID: MON-0042301

Date of inspection: 24/04/2024

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• The Person in Charge will undertake a roster review in house 2 within the service to address any staffing issues therefore enabling the residents to achieve their personal goals for example swimming – 19.07.2024

• The Person in Charge will progress the recruitment of two vacancies to ensure the residents are support by permanent staff – 31.07.2024</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider has restructured the Senior Management team to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management, and oversight.

Under the remit of the HSE's Service Improvement Team the Models of Service sub-group has been merged as part of the Quality, Safety and Service Improvement workstream. The Provider has revised the unannounced visit template and unannounced visits are scheduled up to 31/7/2024. The next bi-annual thematic governance and quality improvement report will be presented to the Board at the end of July.</td></tr>
</table>

A learning management system pilot has commenced in two service areas for staff training and development and aims to implement the system to the rest of the organisation by the end of August. The provider continues to facilitate monthly staff regulatory events. The quarterly properties and facilities plan is presented at senior management for oversight with regard to its monitoring and implementation.
An organisational report is submitted to the provider from the senior management team through the Chief Executive Officer every 2 months. The provider has submitted a business case to the commissioner of services to strengthen the current on-call arrangement. An interim arrangement is being developed with Front Line Manager through the Area Teams agree an on-call system by the 30.06.2024

• The Person in Charge will undertake a Needs Assessment Review of all residents to capture their changing needs and identify the scoring system in place to determine the level of support required by the residents - 28.06.2024

• The Person in Charge will review and update the center's risk register to include assessment of risk posed by the changing needs of the residents and include the control measures required to reduce those risks -14.06.2024

• The Person in Charge and the Named Staff will review all care plans on a quarterly basis to ensure that they are up to date and capture progress or any changing needs. This review will take place in supervision and support and staff meetings -05.07.2024

• The Person in Charge will review the training needs within the designated center on a monthly basis and this will be represented to the training Dept on a quarterly basis. The training needs of all relief staff will be included in this review and a copy of their training records will be available and stored on site – 14.06.2024

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Person in Charge has submitted a request to the maintenance department to undertake general maintenance in garden area and also to repair the gate in 'house 3' – Completed on 27.05.2024

• The Person in Charge will work with the Maintenance Manager to review and identify alternative storage for sanitary/nappy bins for each location. This will help to remove odour's identified in 'house 2' -14.06.2024

• The Person in Charge will work with the Occupational Therapist to review the changing needs of one resident who enjoyed having a bath in 'house 2' and identify aids and equipment to support their needs. – 28.06.2024

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports.

The training module on the revised incident management policy commenced on the 15/05/ 2024. The risk management policy and associated training module are in consultation stage with various stakeholders for organisational implementation.

The Risk Management Framework will be presented to the QSSI workstream for stakeholder engagement.

The pilot project will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review.

• The Person in Charge will review and update the center's risk register to include assessment of risk posed by the changing needs of the residents and include the control measures required to reduce the risks and ensure the residents are supported at all times- 14.06.2024

• The Person in Charge will undertake a full needs assessment review of all residents and ensure the staffing levels meet the assessed need of all residents -28.06.2024

• The Person in Charge has undertaken a risk assessment in regards to the possible risks of introducing a new admission to 'house 2' – 10.05.2024

• An assessment has been completed on the fire containment risk in all locations. All fire doors have been assessed and new door handles have been installed in two houses – 26.04.2024

• The Person in Charge will undertake a roster review in 'house 2' to address the changing needs of the service and assess the risks associated with disturbed sleep in the service – 19.07.2024

• The Person in Charge will identify and assess all relief staff with regards to training and lone working. A copy of their training records will be available and stored on site – 14.06.2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• An assessment has been completed on the fire containment risk in all locations.
All fire doors have been assessed and new door handles have been installed in two house – 26.04.2024

• The Person in Charge will ensure that fire drills are carried out under different scenarios and recording of fire drill will be detailed. This will include the location of the residents in the house and supports they required for evacuation – 28.06.2024

• The Person in Charge will ensure that weekly fire checks are completed in each location and any issues highlighted will be address immediately. Health & Safety Audits will be carried out on a monthly basis by the Person in Charge – 01.05.2024

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The Governance and Clinical oversight Group has been renamed as the Critical Response Team and meets on a quarterly basis. The Neurodiversity training module has commenced with refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and the Listening and Responding Policy has been reviewed and will be considered by key stakeholders prior to implementation. The Inter Clinical Team Working Policy will be completed by the 30.06.2024.

• The Person in Charge will nominate all staff for 'neurodiversity' training program identified within the organization – 31.10.2024

• The Person in Charge will link with the Rights Review Committee in regards to reviewing the restrictive practice identified. – 14.06.2024

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• The organisational safeguarding policy has been reviewed and updated in alignment to the National Safeguarding Vulnerable Person's at Risk of Abuse Policy and Procedure. A safeguarding committee has been established to ensure a robust system is in place to review safeguarding concerns. Safeguarding plans are reviewed with the HSE Adult Safeguarding and Protection Team every six weeks. The organisation will provide face-to-face safeguarding training to all staff by June 2024.

• The Person in Charge has reviewed all staff training and nominated staff for face to face safeguarding vulnerable adults training – 26.06.2024.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	19/07/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/07/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	27/05/2024

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	28/06/2024
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	05/07/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	19/07/2024

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	01/05/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	26/04/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	28/06/2024
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/10/2024

Regulation 07(5)(c)	The person in charge shall ensure that, where a resident’s behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/06/2024
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	26/06/2024