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:	Cheile Creidim 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-0003917
Fieldwork ID:	MON-0040754

About the designated centre

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

The designated centre provides a respite service to 28 identified residents on a shared basis. The service can accommodate a maximum of 3 residents at any one time and residents who use this service have a primary diagnosis of intellectual disability. Residents using this service have mild to moderate care needs and may have additional needs such as behaviours of concern, autism, diabetes and epilepsy. The staffing allocation in the centre varies depending on the needs and number of residents in the centre and residents are supported by a combination of social care assistants and social care workers. There is also a sleep in arrangement to support residents during night time hours and additional night duty staffing is facilitated to meet the care needs of some residents. Each resident has their own bedroom for the duration of their stay and the service operates on average for 26 nights per month. The centre is a single storey building which is located in a suburban area of a large town and transport is provided to facilitate residents to access the community. The centre has an appropriate number of bathrooms and kitchen and dining facilities are also provided. There is one sitting room which is comfortably furnished for residents to relax and additional outdoor and garden space is also available.

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 24 April 2024	10:30hrs to 17:30hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

This inspection was completed to monitor compliance with the regulations in line with the regulatory programme in place at present. Overall, this inspection found that this service was well managed and activities were coordinated for each resident attending for respite in line with their assessed needs. The staff team ensured that this programme is very person-centred and suitable for the needs of each resident attending. The inspector found that there was minimal areas for improvement and that the organisation was progressing on the providers compliance plan response which was still underway at the time of this inspection, which will be discussed later in the report.

The 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 had been published on the HIQA website. In response to the findings of this review, Western Care Association submitted a compliance 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 this inspection a number of actions had been implemented, with more in progress for completion. The provider had made improvements in their governance arrangements. This included an assessment of the senior and frontline management structures and the reconfiguration of service areas with additional multi-disciplinary supports provided. These had occurred in line with timeframes of the provider's compliance plan and the management team met with said that here had been positive changes with regard to communication systems.

On arrival to the centre, the inspector met with the person in charge and staff that were present in the centre. The inspector gave a document called ''nice to meet you'' that inspectors use with the aim of supporting residents to understand the purpose of their visit. The inpector was advised that residents attending for respite would return to the centre later that day. The inspector commenced the inspection in the dining area and was advised that staff would alert the inspector when residents were returning and if they were receptive to meeting and chatting about their service. The inspector found that staff interacted in a professional, calm and respectful manner at all times and that a resident was relaxed, comfortable and at ease throughout this interaction. Chatting about activities, places they liked to attend and plans for the evening ahead. The inspector completed a walk around of

the centre and found that it was well maintained and that at present one job was outstanding in relation to improvements required to the kitchen area. This was highlighted on the organisations "flex" systems and was scheduled in line with priority of tasks.

It was very clear that staff were very familiar with residents' needs and their various ways of communicating. Staff could interpret the behaviours of residents and explain to the inspector what it was they were communicating, and were seen to respond appropriately and effectively to the resident.

From discussions with staff, observations in the centre and a review of records, it was found that residents had a good quality of life, where they made choices about what to do and were supported to be active participants in local community life.

A walkaround of the house found that it was clean warm and well maintained in general. The house was decorated suitably throughout taking in to consideration the preferences and assessed needs of all residents attending for respite breaks.

In summary, the inspector found that residents' safety was paramount and social activities were paramount to all systems the provider had now put in place in this centre. Oversight systems were enhanced by the provider to ensure the quality of care provided monitored effectively. Residents were supported and encouraged choose how they wished to spend their time and that they were involved as in the running of their centre.

Overall, the centre was found to be person-centred to meet the needs of residents who attended this centre. The next two sections of the report present the inspection findings in relation to governance and management of the centre, and describes about how the governance affects the quality and safety of the service provided.

Capacity and capability

The inspection found that the governance and management arrangements in the centre were improved and that the provider's compliance plan response on the targeted inspection programme in 2023 was achieving steady progress as found on this inspection. The provider had made progress with a number of actions from the overview report, which will be discussed under each of the relevant regulations. These areas for improvement will be elaborated on throughout the following sections of the report.

The governance and management arrangements in this centre had changed recently due to the organisation reconfiguring the regions and increasing the management structure and oversight. The inspector found that the new persons employed had settled into their roles. The service provided was person-centred while ensuring that residents were protected from harm. In addition, the provider had completed significant action following the last inspection, which included increased

management, review of maintenance works and ongoing refurbishment internally to improve all living areas for residents. The provider also had further plans to develop the external areas of the centre. The inspector found that the areas for improvement related to the provider's compliance plan and ongoing actions required. These will be expanded on later in this report.

The staffing arrangements in place were reviewed as part of the inspection. A planned and actual roster was available and it showed an accurate account of staff present at the time of the inspection. The provider ensured that the number and skill mix of staff met with the assessed needs of residents and good consistency of care and support was provided. Furthermore, from conversation with the person in charge it was clear that the staffing arrangements were reviewed based on residents attending for respite. This meant that the staff team were actively planning ahead to ensure that the resident's needs were paramount for each respite break.

A review of the governance arrangements highlighted recent changes of a new management structure in place, this was clearly defined and staff were clear about their roles and responsibilities therefore the lines of authority. The person in charge worked alone in this centre but also had responsibility for one other centre and another service awaiting registration.The inspector found that the staff in this centre were very knowledgeable and skilled in their role and in supporting the residents. The annual review of the quality and safety of the service was completed and up to date but, also showed relevant actions for completion, which was linked to the provider compliance plan response. In addition, the six monthly unannounced provider-led audit was completed in the time-line required and a number of actions were identified and actioned. Staffing in place was provided by a core team which provided consistency of care and support provided. Team meetings were taking place regularly. A review of incidents occurring in the centre found that they were clearly documented and if required reported to the Chief Inspector in line with the requirements of regulation 31. The provider also promoted the improvements in the centre to the inspector in relation to a compliance plan submitted in March 2023.

Overall, the inspector found that the governance and management arrangements had significantly improved in this centre which, resulted in a safe and effective service was provided. This led to good outcomes for residents' quality of life and for the care provided in this centre.

Regulation 15: Staffing

The provider had ensured that the number and skill-mix of staff was appropriate for the needs of residents attending this centre for respite. For example staffing was increased when residents with multiple and complex needs attended for respite to ensure consistency of care and support was provided.This was shown clearly on the planned and actual rosters in place for the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The management team showed that an accurate training record was maintained and monitored in this service. All staff had completed all mandatory training at the time of the inspection for example: safeguarding, positive behaviour support, fire training and medication management. In addition, the person in charge also maintained a schedule for refreshers as well as bespoke training such as epilepsy.

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 and arrangements at the centre. The provider aimed to have all actions completed by 31/01/2024. At the time of the inspection eight actions had been implemented with the remainder in progress.

Completed actions included an assessment of the senior and frontline management structures and the reconfiguration of service areas, the establishment of a new incident monitoring and oversight committee and a reinstated human rights committee, and the introduction of new arrangements for unannounced provider visits. in addition, a standardised monthly report writing template was introduced to the service and regulatory information events were provided for staff.

The inspector found that the remaining four actions were commenced and were progressing. The quality, safety, and service improvement department were finalising the review of service audits. The governance and quality improvement framework was in draft form and under review. A training and development project group was established and they had selected an information system which would enhance and support the staff training arrangements in place. This included a review of the policy, procedures and guidelines which were not yet established or embedded into the organisation.

It was clear that the person in charge was very well informed of the ongoing actions taken by the provider to strengthen the governance and management arrangements at both provider and service level. They spoke with the inspector about improvements in communication arrangements, opportunities for individual and shared learning and consistency of the management systems in place. They spoke about that while improvements were ongoing this had a positive impact on the quality and safety of the service provided locally.

In this centre, the inspector found a clearly defined management structure in place. The role of the person in charge was supported by a social care staff and they were skilled and knowledgeable in their role.

The inspector found that there was on-call system in place through the local management team, however it required review to ensure that it was in line with the provider's policy, met the requirements of the service and was sustainable in the long term.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had ensured that the statement of purpose included all required information and adequately described the service. It was also provided in a suitable accessible format if requested by residents attending for respite.

Judgment: Compliant

Regulation 31: Notification of incidents

All the required notifications had been made to the Chief Inspector within the specified timeframes.

Judgment: Compliant

Quality and safety

The inspector found that the service provided in Ceile Creidim respite Service was person-centred and residents were supported to live rewarding lives as active participants when they attended for short breaks.

The person in charge ensured that the resident's health, personal and social care needs were assessed. Care and support plans were developed, as required. Meetings occurred with the resident's family representatives where priorities and goals for the future were reviewed and agreed. Staff spoken with talked about the activities the residents enjoyed which, included attending day services, trips on the transport provided and attending a local places if interest.

As outlined, residents that required support with positive behaviour support had

specialist supports in place. A further meetings were planned after the inspection in order to review and monitor the behaviour support plans in place. The policy on behaviour support was up-to-date and staff training was provided. Restrictive practices were in use in this centre, however, they were reviewed regularly and some were removed recently as they were not longer required. Those used were the least restrictive and only used when necessary.

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 six of these actions. The seventh action had commenced and was in progress. At the time of the inspection the training in neuro-diversity training was in progress, with managers having attended pilot sessions prior to staff attending. Overall, the provider had made improvements in positive behaviour support in the organisation as well as the centre.

There were no open safeguarding concerns at the time of inspection. A review of a safeguarding and protection plan found that it was completed in accordance with local and national policy. It addition, plans were linked to behaviour support strategies and corresponding risk assessments were in place. The safeguarding policy was up-to-date and all staff had completed training. Intimate care plans were available for review. The team leader was clear on what to do if a concern arose and the identity of the designated officer was clearly displayed in the centre. This was an action from the provider's compliance plan.

At this centre the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies. Policies on risk management were available for review and safety statements were up to date. Risk assessments for service level risks were in place and each resident had a personal risk management plan.

The provider had arrangements in place to reduce the risk of fire in the designated centre. These included arrangements to detect, contain, extinguish and evacuate the premises should a fire occur. The fire register was reviewed and the inspector found that fire drills were taking place on a regular basis. Residents had personal emergency evacuation plans and all staff had completed fire training.

As outlined, the premises provided was clean, comfortable and suitably decorated. The inspector found that the centre was homely, welcoming and suitably decorated throughout to ensure that residents short breaks were relaxing in a homely environment.

In summary, residents at this designated centre were provided with a good quality service where their independence and autonomy was promoted. There were good governance and management arrangements in the centre which led to improved outcomes for residents' quality of life and care provided. Ongoing progress with the actions committed to by the provider on their compliance plan would further enhance the service and the quality of the care and support provided.

Regulation 13: General welfare and development

Residents were provided with appropriate care and support in accordance with their assessed needs and preferences, and were supported in personal development.

Judgment: Compliant

Regulation 17: Premises

The design and layout to the premises was appropriate to meet the needs of the residents. The inspector noted that it was a well maintained and suitably decorated centre throughout and there was adequate space to the front and rear of the centre to meet the needs of all residents.

Judgment: Compliant

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through the its compliance plan to complete three actions aimed at improving the risk management arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection two actions were completed and one was in progress.

Actions completed included a review of the risk management policy and the introduction of a quarterly process of incident review.

The inspector found that one action in relation to incident management training was in progress.

In this centre, the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system to responding to emergencies. Policies on risk management were available for review and safety statements were up to date.Risk assessments for service level risks were in place and each resident had a personal risk management plan.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Adequate precautions had been taken against the risk of fire. The management team ensured that regular fire drills were complete in line with local policy. A record of all maintenance for the fire equipment and systems was maintained and the staff team completed monitoring of these systems, such as daily, weekly and monthly checks for example, fire doors, emergency lighting and testing of the fire panel. In addition, Personal emergency evacuation plans (PEEPS) were also in place for each resident clearly guiding all staff on how to support residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider and management team had ensured that suitable arrangements were in place for effective medication management in the centre. This included suitable storage arrangements, monitoring of all medication on attendance for respite. All staff were trained in medication management and completed refreshers as required. Audits were completed regularly to monitor medication management practices but also to identify any gaps or areas for improvement in line with local policy.

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 six of these actions. The seventh action had commenced and was in progress.

Completed actions included the appointment of an interim head of clinical and community support and the appointment of additional multi-disciplinary supports. Under the leaderships of the psychology team, a governance and clinical oversight group and a behaviour support oversight group was established in order to co-ordinate the response to critical incidents. A review of the role and function of the psychology team was completed and guidance on the referral pathways was developed.

The inspector found that one action was in progress. The training module in neuro-diversity was developed, a pilot was completed and that full roll out of the training

module was planned. Managers had commenced attending pilot training prior to staff attending.

In this centre, the inspector found that residents that required support with positive behaviour support had specialist supports in place. The policy on behaviour support was up-to-date and staff training was provided.

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 were completed.

These included the establishment of a safeguarding oversight committee, updating of the providers safeguarding and protection policy and the introduction of a six monthly review system for open safeguarding plans. In addition, staff had access to face to face training in safeguarding and protection and new systems were in place to improve staff awareness of the contents and actions of open safeguarding plans.

At this centre, the inspector found that residents were supported to understand the need for self-care and protection. If safeguarding plans were used, the inspector found that the team leader had a good awareness of the plans requirements and that the actions were integrated into the behaviour support strategies and personal risk management plans.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were upheld, and the privacy and dignity of residents was respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cheile Creidim Respite Services OSV-0003917

Inspection ID: MON-0040754

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:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
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. A learning management system pilot has commenced in two service areas for staff training and development and the aim is 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 to agree an on-call system by the 30/06/2024	
Regulation 26: Risk management procedures	Substantially 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.	
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 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.	

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 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.	Substantially Compliant	Yellow	30/06/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's	Substantially Compliant	Yellow	30/06/2024

	behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			