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:	Abbeydeale Residential Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	24 May 2024
Centre ID:	OSV-0003918
Fieldwork ID:	MON-0042266

About the designated centre

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

Abbeydeale Residential Service is a centre run by Western Care Association and is located in a town in Co. Mayo. The centre provides residential care for up to seven male and female residents, who are over the age of 18 years and have an intellectual disability. The centre comprises of three premises located within close proximity to each other, where residents have access to their own bedroom, some en-suite facilities, shared bathrooms, shared communal areas and external garden spaces. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Friday 24 May 2024	10:30hrs to 14:30hrs	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 the service was meeting the needs of the residents who lived there as well as supporting them to lead very active lives. The inspector found that the provider was working on the regulatory programme in place, and the local management team in this centre were found to be adhering to maintaining and sustaining a good service while responding to areas for improvement where required. This included regularly reviewing residents compatibility needs and activities. This centre was progressing in accordance with the providers compliance plan which was still underway at the time of this inspection, which will be discussed later in the report.

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 governance and oversight of Western Care Association centres 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 the 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.

On arrival the inspector met with the person in charge who facilitated the inspection. The inspector provided identification provided their identification on arrival to residents and staff. The inspector noted and was advised that residents were attending their day programmes and scheduled activities and resident was enjoying being supported with home based activities in line with their aging profile and preference. Since the last inspection the inspector noted that a new admission had occurred and this resident had transitioned into the centre successfully. At all times, staff were heard speaking and interacting in a professional and respectful manner whilst offering assistance and choice. Throughout the day the inspector also noted that staff acted in a calm manner, were knowledgeable of the residents support needs, preferences and communication styles but also of their behaviour support needs where required.

Abbeydeale residential service comprised of three houses located in a residential

area close to a busy town in co. Mayo. Each of the residents had their own bedroom and enjoyed suitable facilities. The person in charge monitored and maintained each house to ensure that all residents were enjoying and receiving a good quality service.

Overall, 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 in their local community. In addition, the inspector noted that the management team responded to residents individual needs by increasing staffing to allow for additional activities where identified. The staff team spoke about upcoming local festival activities and how the residents enjoyed attending and partaking of local events with staff support.

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

Overall, this centre was found to focus on all of the residents care and support needs, but also ensuring that each individual was provided opportunities and choice on a daily basis in this centre. The next two sections of the report present the inspection findings in relation to the governance and management of the centre, and describes how the governance and management affects the quality of the service provided.

Capacity and capability

Overall, the inspector found that this centre was well monitored and the management team had effective oversight of this centre, which ensured that the residents received support and care in line with their assessed needs and received a good quality service. The inspector found that aside from the regulatory programme in place, there were no areas for improvement and that the actions outstanding from the regulatory programme, were still underway at the time of the inspection.

While the governance and management arrangements had changed in the organisation due to organisational reconfiguring of service regions, increasing the management oversight, the management structure in this centre remained unchanged since the targeted inspections began. The inspector noted that the service in place in this centre was person-centred, focused on the residents needs and promoted individual and community activity for all residents. The inspector found that areas for improvement related to the provider's compliance plan and ongoing actions required. The inspector went through the status of all actions on the day of the inspection and noted the status of all actions through conversation with the person in charge and from a review of all documentation. The inspector also

reviewed all relevant documentation in relation to a registration renewal application and this will be discussed under each regulation.

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 the assessed needs of residents and ensured that a good consistency of care and support was provided in this centre.

A review of the governance arrangements in the organisation highlighted and showed a more robust structure in place, which was clearly defined and staff were clear about their roles and responsibilities in the centre but were also knowledgeable of the lines of authority. The inspector found that the management team had a suite of audits in place and these were completed daily, weekly, monthly and quarterly. This included audits of medication management, residents personal plans, infection prevention and control, cleaning and health and safety. Where actions were identified, the persons responsible for completion were clearly identified and on the audits completion of these activities were shown. In addition, the six monthly unannounced provider-led audit was completed in line with the time-line specified and a number of actions were identified and addressed.

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.

Overall, the inspector found that the governance and management arrangements had significantly improved in the organisation 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.

Registration Regulation 5: Application for registration or renewal of registration

All the required documentation to support the application to renew the registration of the designated centre had been submitted.

Judgment: Compliant

Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents. The provider monitored staffing levels and increased them when required for individual resident needs.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training and additional training specific to the needs of residents, and were appropriately supervised. Training included; safeguarding, fire safety, medication management, epilepsy management and first aid. The management team also offered bespoke training as identified in quarterly training needs audits.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information as specified in the regulations and was available for review in the centre. The inspector found that the person in charge had maintained the directory or residents and ensured that the information was up to date on the day of the inspection, showed all residents living in the centre, and any time residents spent away from the centre.

Judgment: Compliant

Regulation 22: Insurance

The provider had appropriate insurance in place as required by the registration renewal regulations.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector found that the service provided in Abbeydeale residential service was person-centred and residents were supported to enjoy rewarding lives as active participants in their community.

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 management team was very well informed of the ongoing actions taken by the provider to strengthen the governance and management arrangements.

Furthermore, the inspector found that the management team had ensured that this centre had maintained the management systems to ensure a good quality service was in place for all residents. This included a robust management structure with clear lines of accountability and responsibility. The person in charge knew all residents well and attended all review meetings where individual care objectives and goals were discussed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose described the all of the information as specified by the regulations, and adequately described the service. This included for example, a clear outline of the service provided and supports available to residents. In addition, the statement of purpose was also available in an accessible format if required.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. A complaints log was maintained,

and complaints and complements were recorded and acted on appropriately.

Judgment: Compliant

Quality and safety

The staff team 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 additional hours to support residents having individual time out of the centre to sample activities of preference.

As outlined, residents that required support with positive behaviour support had specialist supports in place. Further meetings were planned 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. Minimal restrictive practices were in use in this centre, with those in place reviewed regularly and when agreed removed when no longer required. Those practices used were the least restrictive and only used when necessary.

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 person in charge and staff were 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 centre's premises provided was clean, comfortable and suitably decorated throughout. The provider had taken action to ensure that matters identified previously were addressed. This included the painting and decorating of the centre. This house met the requirements of the assessed needs of residents at the time of this inspection.

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 fo life and care provided. Ongoing progress with the

actions committed to by the provider on their compliance plan would further enhance the service and 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. Some residents attended day services and some enjoyed home-based activities and aging specific supports.

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 6: Health care

Residents had access to allied health services, such as general practitioners (GP), dental services, physiotherapy, mental health and behaviour support services as needed. Comprehensive care plans were in place to ensure that all staff supporting residents were guided in their role. Residents had access to annual reviews with

these service or sooner where required.

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 still in progress which related to the development of a training module in neuro-diversity. A pilot had been completed and roll out of the training module had commenced with management and only some staff at the time of the inspection.

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 provider's 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 and residents rights were paramount in this centre. For example, additional staffing was put in place to support or provide residents individual opportunities for activities of their preferences.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Abbeydeale Residential Services OSV-0003918

Inspection ID: MON-0042266

Date of inspection: 24/05/2024

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 aims to implement the system to the rest of the organisation by the end of the year. 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 for on call is in place across a number of service areas and some discussions are ongoing in one area. In addition, the provider is working to provide an interim on call arrangement across all Areas and Departments.	
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 framework 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. Following consultation, a draft framework and training module will be presented to the Senior Management Team which will include stakeholder feedback on the 23/07/2024. 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 and is being rolled out to all staff in the organisation 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 including the Chairperson of the Rights Review Committee on the week commencing 15/07/24 prior to implementation. The Inter Clinical Team Working policy will be implemented once the Clinical Lead has commenced in their position.	

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	30/08/2024
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	30/08/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's	Substantially Compliant	Yellow	30/09/2024

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