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:	Ash Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	10 January 2023
Centre ID:	OSV-0004055
Fieldwork ID:	MON-0034667

About the designated centre

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

Ash Services provides residential and respite services for up to eleven residents with an intellectual disability. This centre consists of two houses that are located next door to each other in a housing estate in a rural town in Co. Galway. One of the houses provides six full-time residential places, and the other house is a five bedroom house providing rotational respite services for up to eleven individuals. Some of the residents have severe intellectual disability with mobility problems, other residents have autism and require 1:1 support. Each house contained suitable communal areas, such as two sitting rooms, dining rooms, kitchen and utility room, bathrooms, Residents' have their own bedrooms which are suitably decorated to meet their needs and wishes. The residents are supported by a team of social care staff and there are three staff on duty at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Tuesday 10 January 2023	09:30hrs to 17:30hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to follow up on issues identified at the last inspection and to monitor ongoing compliance with the regulations.

On arrival at the centre, staff on duty guided the inspector through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene and face covering.

The designated centre comprised of two houses which were located beside one another in a residential area of a rural town. One of the houses provides six full-time residential places and the other house is a five bedroom house providing rotational respite services. The inspector visited the two houses and met with residents and staff in both. The inspector also met with the person in charge and team leader. At the time of inspection, there were six residents living in the designated centre and four residents were availing of a respite service. The inspector met with four residents who were sharing one house and also briefly met with three residents who were availing of respite services. All residents normally attended day services during the weekdays.

On the morning of inspection, some residents had already left the centre to attend their respective day services. There were three residents who had remained at home as they had been feeling unwell due to respiratory issues. Two of the residents remained in bed until the late morning while another relaxed in the sitting room. As these residents would normally have attended day services during the week days, two staff employed in the day services were allocated to support these residents during the day while they remained in their home. The residents were unable to tell the inspector their views of the service but appeared in good form, content and comfortable in their environment and in the company of staff. Staff were observed to be attentive, spending time and interacting warmly with residents. During the day, residents were supported with personal care, their mid-day and evening meals, relaxed watching television and appeared to enjoy doing some light exercise and dance to music. Throughout the day, residents were observed enjoying the interaction and company of staff. Residents were observed to have unrestricted access to all areas of the house and were observed coming and going from their bedrooms and using the communal areas of the house as they wished.

Staff reported that residents had been supported to have breakfast in bed. One resident indicated how they had enjoyed having scrambled eggs for breakfast. The inspector observed the lunch time and evening meal experience. Staff outlined how residents were involved and had choice in selecting their preferred food and meal options. Residents were consulted with regarding their preferred meal options at the weekly house meetings. Minutes of meetings reviewed showed that food and menu choices were discussed weekly. Choice was also offered on a daily basis, for example, staff offered a selection of options and residents could choose their preferred option. Residents were also supported to eat out and get takeaway meals.

Staff were knowledgeable regarding the nutritional needs and dietary requirements of residents. Residents who required modified diets were supported in line with the recommendations of the speech and language therapist (SALT). Staff had completed training on feeding, eating, drinking and swallowing difficulties (FEDS).

During the afternoon, the inspector briefly met with some residents when they returned to the centre from their day service. They appeared happy and greeted staff in a familiar way. Residents who were availing of the respite service appeared content and comfortable as they relaxed watching television while the evening meal was being prepared. Staff informed the inspector how some residents liked to prepare their own lunch to take with them to day service the following day. Another resident availing of respite service was supported to go for a drive with staff.

Staff spoken with, documentation and photographs reviewed indicated that residents were supported to partake in a variety of activities that they enjoyed both in the centre and in the local community. The centre was located in an area with good access to a range of facilities and amenities. There was easy access to a range of shops, restaurants, coffee shops, post office, pharmacy and other businesses. It was close a variety of woodlands, parks and lakeside amenities where residents liked to visit for walks and picnics. Staff reported that residents enjoyed going for drives, day trips, going to the cinema, bowling and eating out. Residents also enjoyed spending time at home relaxing, listening to music, watching movies and helping out with various tasks in the house. Some residents enjoyed getting their nails painted, having facials and getting their hair done. Residents could access religious services and a list of weekly religious services was displayed. Staff confirmed that one of the residents enjoyed attending mass at the local church. Residents weekly participation in activities were recorded.

Residents enjoyed meeting with and visiting family members. Some residents went home to stay with family members on a regular basis while others went home for day visits. Visiting to the centre was being facilitated in line with national guidance. There were no visiting restrictions in place and there was adequate space for residents to meet with visitors in private if they wished. Staff confirmed that visitors were welcome, some residents received visits from family members on a regular basis. The entrance hall was supplied with a hand sanitising dispenser unit and signage was displayed as a reminder to sanitise hands.

The centre comprised of two purpose built single storey houses located beside each other. The respite house could accommodate up to 5 residents in single bedrooms. There was adequate assistive equipment and appliances to meet the assessed needs of residents. The inspector noted that there was inadequate storage for equipment, much of which was inappropriately stored in residents bedrooms and bathrooms.

Accommodation for up to six residents was provided in the residential house. Each resident had their own bedroom. Both houses were comfortable, warm, suitably furnished and decorated in a homely manner. The houses were spacious and bright with a good variety of communal day spaces, dining rooms, well equipped kitchens and laundry rooms as well as an adequate number of suitably adapted toilets, bathrooms and shower rooms provided in each house. Both houses were found to

be well-maintained and visibly clean. Improvements works identified during the last inspection had been addressed. Residents had easy access to well maintained garden and patio areas. The houses were accessible with suitable ramps and handrails provided.

Residents bedrooms were comfortably decorated, suitably furnished and personalised. Bedrooms had adequate storage for personal belongings and were personalised with items of significance to each resident including family photographs. Residents had been consulted and involved in selecting their preferred wall colours and in choosing soft furnishings for their rooms.

In summary, the inspector observed that residents were treated with dignity and respect by staff. There were stable staffing arrangements in place and staff were well known to the residents, many of the staff had worked in the centre for several years. Staff were very knowledgeable regarding the individual needs, likes, dislikes and interests of the residents. It was evident that staff prioritised the welfare of residents, and that they ensured residents were supported to live person-centred lives.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

This unannounced inspection was carried out to

- monitor compliance with the Regulations
- follow up on non-compliance's identified at the previous inspection
- following notification to a change in the management arrangements in the centre.

The governance and management arrangements in place strived to ensure a quality service. The management team had systems in place to oversee the quality and safety of care and improvements identified were in progress. Non compliance's identified during the previous inspection had generally been addressed, however, adequate storage for equipment had still not been provided. Some improvements and further oversight were required to personal planning and personal planning documentation, recording of actions taken in response to complaints and further clarity was required in relation to some aspects of fire safety.

There had been a number of changes to the management arrangements in the centre since the previous inspection. A new person in charge had been appointed in July 2022 and a new assistant director of client services had been appointed in

November 2022. A team leader had also been appointed to each house to support the person in charge in their role. The management arrangements in place were reflected in the recently updated statement of purpose which had been submitted to the Chief Inspector.

The person in charge had the necessary experience and qualifications to carry out the role. They were also the person in charge for two other designated centres. They had 16 hours a week allocated to the operational management and administration of the centre. They were knowledgeable regarding the assessed needs of residents and strived to ensure that good quality of care was provided. Team leaders in each house had both been allocated 12 hours a week to support the person in charge in their operational role. There was an on-call management rota in place for out of hours at weekends and the assistant director of client services was currently on-call during the weekdays. There were three staff on duty at night time and staff reported that they could support one another in the event of an emergency at night time.

The inspector found that the staffing levels and mix were in line with that set out in the statement of purpose. The person in charge confirmed that there were no current staffing vacancies.The staffing roster reviewed indicated that there was a regular staff pattern of consistent staff to ensure continuity of care. There were three staff on duty in each house during the morning and evening time and three staff on duty at night time (one waking night staff in the residential house, one waking and one sleeping staff member in the residential house). Photographs of staff were displayed so that residents could be reminded or check as to which staff were on duty.

Training was provided to staff on an on-going basis. Records indicated that all staff had completed mandatory training. Staff spoken with confirmed that they had completed mandatory training including fire safety, safeguarding and behaviour management. Additional training in various aspects of infection control, epilepsy, administration of medications, respiratory emergency and safe use of hoists had also been provided to staff.

The management team had systems in place to monitor and review the quality and safety of care in the centre. The person in charge advised that the annual review for 2022 was due to be completed later in January 2023, and consultation with residents and their families was planned to inform this review. Unannounced audits were being carried out twice each year on behalf of the provider. The most recent review which took place in December 2022 was found to be comprehensive and had identified a number of improvements which were clearly set out in an action plan. The person in charge confirmed that some of the improvements identified had already been completed while others were still work in progress. For example, the inspector noted that improvements works on the reorganisation and updating of residents files was in progress. The person in charge had a audit schedule in place which they used to assist them in maintaining oversight of the quality and safety of care in the centre. Monthly audits had taken place in areas such as fire safety management, medication management, infection, prevention and control, finances and residents files. The results of audits were discussed with staff at the monthly

team meetings in order to share learning and bring about improvements to the service. Issues identified at the last inspection in relation to reviewing the impact of a restrictive practice on the rights of a resident had been completed. A risk assessment had been completed with input from staff and multi-disciplinary team which set out both positive and negative impacts on the rights of the resident along with a clear rationale for its use. The person in charge advised that they were committed to ensuring on-going review of all restrictive practices in use with a view to removing some and ensuring that the least restrictive practices were in use.

The inspector was satisfied that complaints were managed in line with the centre complaints policy, however, records maintained to support the management of complaints required some improvements. There was an easy read information leaflet available explaining clearly how to make a complaint displayed in the centre. The minutes of residents meetings showed that the complaints process, advocacy and the right to feel safe had been discussed. There were systems in place to record and investigate complaints. Three complaints were logged on the computerised system during 2022. While the inspector was satisfied that all complaints had been investigated and acted upon appropriately, records available on the computerised system did not reflect all actions taken on foot of the complaints or the complainants satisfaction or not with the outcome. There were no open complaints at the time of inspection.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives. They were positive in attitude and showed a willingness to comply with the regulations. They were well known to residents and staff in the centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and mix were in line with that set out in the statement of purpose. The staffing roster reviewed indicated that there was a regular staff pattern of consistent staff to ensure continuity of care. There were three staff on duty in each house during the morning and evening time and three staff on duty at night time (one waking night staff in the residential house, one waking and one sleeping staff member in the residential house).

Judgment: Compliant

Regulation 16: Training and staff development

All staff who worked in the centre had received mandatory training in areas such as fire safety, behaviour support, manual handling and safeguarding. Additional training was provided to staff to support them in their role including infection prevention and control, hand hygiene, putting on and taking off PPE (personal protective equipment), medicines management, management of epilepsy, respiratory emergency and safe use of hoists.

Judgment: Compliant

Regulation 23: Governance and management

Some improvements and further oversight were required to personal planning and personal planning documentation, recording of actions taken in response to complaints, to providing adequate storage for equipment and further clarity was required in relation to some aspects of fire safety.

The provider had not fully implemented its own compliance plan which was submitted to the Chief Inspector following the last inspection in that adequate storage for equipment had still not been provided in one of the houses.

The fire safety consultants report completed following the last inspection was not available for review on the day of inspection. The local management team and staff were not aware of the findings or recommendations from the review and therefore there was no learning as a result.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Some improvements were required to the records of complaints, to include any investigation into a complaint, outcome of the complaint, any action taken on foot of a complaint and whether or not the complainant was satisfied with the outcome.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents received a good quality and person-centred service where residents' rights and individuality were respected. Residents who the inspector met with appeared to enjoy living at the centre, appeared to be comfortable in their environment and with staff supporting them. Further oversight and improvements were required to personal planning, care planning and personal planning documentation and further clarity was required by staff in relation to the fire alarm panel and to the findings or recommendations as a result of the fire safety consultants review.

Residents had timely access to General Practitioners (GPs), out of hours GP service, consultants and a range of allied health services. A review of a sample of residents files indicated that residents had been reviewed by the physiotherapist, occupational therapist (OT), SALT, dietitian and psychologist. Staff spoken with confirmed that some residents were regularly seen by the chiropodist while attending the day service. Residents had also been supported to avail of the national health screening and vaccination programmes. Files reviewed showed that residents had an annual medical review. Each resident had an up-to-date hospital passport which included important and useful information specific to each resident in the event of they requiring hospital admission.

The inspector reviewed a sample of residents files including the files of residents with high risk of falls, specific healthcare needs and with restrictive practices in place. While there was evidence that residents' health care needs had been assessed and care plans were found to be place, information was fragmented and located in a variety of different folders making it difficult to obtain a comprehensive overview of the residents overall health and social care needs. The person in charge and team leader had identified this issue and had commenced the process of reviewing, updating and reorganising residents files.

Further oversight of personal planning was required and supporting documentation required review. There was limited evidence in files that residents had been supported to identify and achieve personal goals. The person in charge advised that planning meetings took place at the day service and were held annually with residents and their family representatives to discuss and identify goals. A sample of these files were brought from the day service to show to the inspector. The names of those responsible for pursuing objectives in the plan within agreed timescales were not identified or recorded. There were no formal review meetings held to discuss progress or effectiveness of the plans. The inspector was shown some photographs to evidence some residents' achievement of goals. For example, a resident planting strawberries, cooking with friends, getting their hair done, visiting the post office, making a cake and setting the table.

The management team had taken measures to safeguard residents from being harmed or suffering abuse. All staff had received specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm. There were

personal and intimate care plans to guide staff. The support of a designated safeguarding officer was also available if required. Preliminary screening was completed to assess if there were grounds for concern or not and safeguarding plans were developed where required.

The inspector noted that a resident who required support with behaviours of concern had a plan in place outlining triggers and supporting actions. Staff were knowledgeable regarding these recommendations and all staff had received training in managing behaviours of concern. Improvements were noted to the management of restrictive procedures in use. Restrictive practices in use were logged and included the use of an audio visual monitor, bed rails, safety beds, lap belts, lap tray, specialised chairs, chemical restraint and restricted access to the kitchen. Some restrictions were in regular use while others had not been used for several months. The inspector reviewed a sample of records relating to some restrictive practices in use. Risk assessments for their use had been completed, there was evidence of multi-disciplinary input into the decision taken to use the restraints, there were rationales outlined for their use, there was evidence of other alternatives that had been tried or considered and there were protocols in place for some restrictive practices including the use of a audio visual monitor. However, the protocol in use had not been updated since 2018 and the person in charge advised that they were waiting on an updated protocol from the behaviour support therapist. There was no protocol in place for the use of bed rails. The use of restrictive practices were being logged on a daily basis indicating the times and duration of use. Staff confirmed that safety checks were carried out every 15 minutes at night time but these checks were not recorded. The person in charge advised that they were committed to ensuring on-going review of all restrictive practices in use with a view to removing some, continuing to trial alternative less restrictive procedures and ensuring that the least restrictive practices were in use.

The centre which comprised of two houses was designed and well equipped with aids and appliances to support and meet the assessed needs of the residents living there, however, there was still inadequate storage for equipment in one house. There were many large items of assistive and specialised equipment being stored inappropriately in communal areas and bathrooms. The centre was comfortable, warm, visibly clean, furnished and decorated in a homely style. It was well maintained and areas requiring improvement identified during the previous inspection had been addressed. New flooring had been provided to the offices, new counter tops had been provided to kitchen areas and two showers had recently been replaced.

There was clear guidance and written protocols in place to direct cleaning of the centre. The person in charge had developed a comprehensive cleaning manual outlining clear guidance and instructions for staff regarding cleaning protocols for all areas of the centre including equipment in use. Daily, weekly and night time cleaning records were being completed. The laundry area and cleaning stores were maintained in tidy and clean condition. Cleaning equipment was appropriately stored. Weekly infection prevention and control audits were completed, the results of recent audits reviewed indicated good compliance. All staff had completed a range of infection prevention and control training. Throughout the inspection, staff

were observed to be diligent in performing hand hygiene and in wearing appropriate face masks in line with current public health guidance. Infection, prevention and control continued to be an agenda item for resident and staff meetings.

Some aspects of fire safety management and evacuation required further clarity. The person in charge confirmed that following the last inspection a fire safety consultant had carried out a review. However, this report was not available for review on the day of inspection, the local management team and staff were unaware of any findings or recommendations as a result of the review. There was an L1 addressable fire alarm system in place. The local management team were unable to confirm if the information displayed on the fire panel in the event of fire corresponded with the room descriptors as displayed on the centre floor plan displayed adjacent to the panel. The fire alarm was serviced on a quarterly basis and fire equipment had been serviced in May 2022. All staff had received fire safety training. Regular fire drills were carried out involving staff and residents. Further fire drills were scheduled in January 2023. All fire exits were observed to be free of obstructions. Fire safety and the importance of fire drills had been recently discussed at residents meetings. Fire safety had also been discussed at recent staff meetings. All residents had a personal emergency evacuation plan in place. The night time fire evacuation protocol in place outlined guidance for staff on the evacuation of all residents from the centre. There were two staff on duty at night time in one of the houses and one could assist staff in the other house in the event of an emergency at night time. The person in charge completed monthly fire safety audits, no issues had recently been identified.

Regulation 11: Visits

Visiting to the centre was being facilitated in line with national guidance. There was plenty of space for residents to meet with visitors in private if they wished. Residents received regular visits from family members, while others were supported to visit family at home.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to take part in a range of activities both at the centre and in the community. Suitable support was provided to residents to achieve this in accordance with their individual choices, interests and their assessed needs.

Judgment: Compliant

Regulation 17: Premises

There was still inadequate storage for equipment in one house. There were many large items of assistive and specialised equipment being stored inappropriately in communal areas and bathrooms. This issue had been identified at the previous inspection and the providers compliance plan response submitted to the Chief Inspector indicated that the issue would be addressed by 31 May 2022.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the on-going review of risk. Risk identified during the last inspection had been addressed. There was a recently updated risk register in place and individual risk assessments were also in place. The person in charge continued to review incidents on a monthly basis and regular audits were completed in relation to fire safety. Incidents, learning from incidents, health and safety, fire safety, COVID-19 and medicines management continued to be discussed at the monthly team meetings

Judgment: Compliant

Regulation 27: Protection against infection

There were measures in place to control the risk of infection in the centre. Issues identified during the previous inspection had been addressed. There was clear guidance and written protocols in place to direct cleaning of the centre. All staff had completed a range of infection prevention and control training. Throughout the inspection, staff were observed to be diligent in performing hand hygiene and in wearing appropriate face masks in line with current public health guidance.

Judgment: Compliant

Regulation 28: Fire precautions

Some aspects of fire safety management required further review. Further clarity was required in relation to information displayed on the fire alarm panel in the event of fire and also regarding the location and layout of fire compartments in the centre. The local management team were unable to confirm if the information displayed on

the fire panel in the event of fire corresponded with the room descriptors as displayed on the centre floor plan displayed adjacent to the fire panel. The fire safety consultants report completed following the last inspection was not available for review, staff were unaware of any findings or recommendations as a result of the review.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Further oversight of personal planning was required and supporting documentation required review. There was limited evidence in files that residents had been supported to identify and achieve personal goals. The person in charge advised that goal planning meetings took place in the day service, were held annually with residents and their family representatives to discuss and identify goals. The names of those responsible for pursuing objectives in the plan within agreed timescales was not identified or recorded. There were no formal review meetings held to discuss progress of goals.

Judgment: Substantially compliant

Regulation 6: Health care

Staff continued to ensure that residents had access to the healthcare that they needed. Residents had regular and timely access to GPs and health and social care professionals. A review of a sample of residents files showed that residents had been referred and recently assessed by a range of health and social care professionals. Residents were supported to avail of vaccine programmes.

Judgment: Compliant

Regulation 7: Positive behavioural support

While improvements were noted to the management of restrictive procedures in use some further improvements were required to ensure compliance with national policy. The protocol in place for use of an audio visual monitor was last updated in 2018, the person in charge advised that they were waiting on an updated protocol from the behaviour support therapist. There was no protocol/care plan in place for the use of bed rails. Staff confirmed that safety checks were carried out every 15

minutes at night time but these checks were not recorded.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding of residents was promoted through staff training, management review of incidents that occurred and the development of comprehensive intimate and personal care plans. Safeguarding plans were in place as appropriate.

Judgment: Compliant

Regulation 9: Residents' rights

Issues identified during the previous inspection had been addressed. Residents had access to advocacy services. Staff were observed to interact with residents in a caring and respectful manner. The residents had access to televisions and information in a suitable accessible format. Residents were supported to attend religious services. Residents continued to be consulted with on a daily basis and at regular weekly house meetings. Topics recently discussed including advocacy and rights, right to feel safe, safeguarding and personal care plans.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	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 Ash Services OSV-0004055

Inspection ID: MON-0034667

Date of inspection: 10/01/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Quality Management Information System was updated on the day of the inspection 10/01/23 with the complainants response to the handling of the complaint. A complaints, compliments and comments folder has been implemented which will contain a copy of same and a recording log to ensure correct and accurate recording. The Fire and Security company were contacted on the day of inspection 10/01/23 and are scheduled to visit the Ash Services by the 28/02/23. The Fire and Security company will ensure that the details on the fire panel correspond with the details on the floor plans. Verbal confirmation has been obtained from the fire engineer in relation to the previous HIQA action plan verifying that the buildings in Ash Services are compartmentalized and can be evacuated horizontally as stated in correspondence. Written correspondence to be sent by email by the 28/02/23.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Quality Management Information System was updated on the day of the inspection 10/01/23 with complainants response to the handling of the complaint. A complaints, compliments and comments folder has been implemented 12/01/23 which will contain a copy of same and a recording log to ensure correct and accurate recording.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Shannon respite has a large dining room area which will be partially sectioned off to facilitate storage for large pieces of equipment. Date for completion of this work is 30/06/23.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Fire and Security company were contacted on the day of inspection 10/01/23 and are scheduled to visit the Ash Services by the 28/02/23. The Fire and Security company will ensure that the details on the fire panel correspond with the details on the floor plans.

Verbal confirmation has been obtained from the fire engineer in relation to the previous HIQA action plan verifying that the buildings in Ash Services are compartmentalized and can be evacuated horizontally as stated in correspondence. Written correspondence to be sent email by the 28/02/23.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Changes to the existing key-working system are currently under review, this system will involve a review of all residents' goals, measuring goals and a monthly progress report of meeting goals. Staff will complete training pertaining to this area and goals will be included at the monthly staff meetings as a regular topic for review.

Residential staff will take on a more responsible role where key-working is concerned and regular reviews will be held with day service to measure goal progression.

Goal plans have been developed and a service user key-working folder has been introduced. Regular key-working sessions will be completed with service users to ensure that both sort term goals and long term goal are being achieved.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
An updated protocol for the audio monitor was sent on the 11/01/23, however this protocol requires additional information. A meeting is scheduled for the 25/02/23 with behavior support to further develop the protocol for the use of the audio visual monitor.

The Occupational Therapy department was contacted on the day of inspection 10/01/23 and a protocol for the use of bedrails and bed bumpers was requested and is to be completed by the 28/02/23.

A staff recording sheet for 15-minute checks at night-time was introduced on the day of inspection 10/01/23, this recording sheet will also confirm that staff have checked the bedrails and bumpers throughout the night to ensure health and safety.

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 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2023
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	28/02/2023
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points	Substantially Compliant	Yellow	28/02/2023

	and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	10/01/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	28/02/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall	Substantially Compliant	Yellow	28/02/2023

	assess the effectiveness of the plan.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	28/02/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	28/02/2023