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:	Grange View Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	27 May 2024
Centre ID:	OSV-0004063
Fieldwork ID:	MON-0041326

About the designated centre

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

Grange View Services is a designated centre operated by Ability West. The centre can provide residential care for up to five male and female adults, who are over the age of 18 years, with an intellectual disability. The centre is located on the outskirts of a town in Co. Galway and comprises of one large bungalow dwelling. Here, residents have their own bedroom, shared bathrooms, and communal use of a kitchen, dining room, sitting room, laundry room and staff office. There is also an enclosed garden area for residents to use, if they so wish. Staff are on duty both day and night to support the residents who live in this service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Monday 27 May 2024	12:00hrs to 16:15hrs	Anne Marie Byrne	Lead
Monday 27 May 2024	12:00hrs to 16:15hrs	Ivan Cormican	Support

What residents told us and what inspectors observed

This was an unannounced inspection that was carried out to assess the provider's compliance with the regulations. The day was facilitated by the person in charge, the team leader and person participating in management. The inspectors also had the opportunity to meet with two of the residents, and with one staff member. Overall, there were some good practices observed in areas, such as, staffing, assessment and personal planning and management of residents' finances. However, significant improvements were found particularly to safeguarding and governance and management, with an immediate action also being issued to the provider in relation to medication management. This will be discussed in further detail later on in this report.

This designated centre comprised of one large bungalow house located on the outskirts of a town in the West of Ireland. The centre was spacious in layout, with each resident having their own bedroom, access to shared bathrooms, a sitting room, kitchen and dining area, laundry room and staff office. The layout of the centre also allowed for one particular resident to have their own living area which was adjacent to their bedroom and bathroom. There was also a large enclosed garden area for residents to use as they wished, which contained tables and seating areas. Residents' bedrooms were personalised to their own tastes, with many having photographs displayed, one resident had a voice activated device to play their music, and many others proudly accessorised their bedrooms with items of interest to them. Some residents responded well to more minimalist furnishing of their bedrooms, and this was how their bedrooms were presented. In recent times, some rooms in the centre had been redecorated, which brightened and freshened up these areas of the house. At the time of this inspection, local management were awaiting a commencement date to complete further upgrade works, to include, a new kitchen and laundry room, provision of new wardrobes to bedrooms, and further re-decoration works.

There were five residents living in this centre, all of whom had lived together for a number of years. Many had complex assessed needs, requiring staff support in relation to safeguarding, social care and positive behavioural support. There was also a high number of restrictive practices in use in this centre, which were assessed as being required, so as to ensure residents' safety at all times. Furthermore, high supervision arrangements were also required for most of these residents, to ensure no negative peer-to-peer interactions, and to also meet the requirements of safeguarding arrangements, in accordance with the recommendations set out in safeguarding plans. Fundamental to implementation of all of this was the adequacy of this centre's staffing arrangement. Where residents were assessed as requiring one-to-one support, this was consistency provided by staff members who were very familiar with the assessed needs of these residents, and the service they received.

All five residents lived active lifestyles, and attended day services during the week. Many often stayed at home with family for overnight visits, some liked to go for

walks, and others took part in other activities of their choice, while some enjoyed spending time relaxing at home. Due to the behavioural support needs of some residents, many responded very well one-to-one staff engagement when doing social activities, and the adequacy of this centre's staffing arrangement allowed for this. As some had complex behavioural support needs, staff were vigilant in their planning of activities with these particular residents, and had effectively established certain activities that these residents responded well to. There was transport allocated to this centre, which allowed for residents to get out on day trips and access local amenities.

Later on in the afternoon, residents began to return home from their day service. There was a pleasant, friendly and warm greeting for them by staff, who prepared cups of tea and snacks for them. Due to their assessed communication needs, they didn't speak directly with the inspectors about the care and support that they received; however, they did shake the inspectors' hand and were observed to respond well to staff supporting them, while staff explained to them the nature of the inspectors' visit to their home.

As earlier mentioned, there were some good practices observed in this centre, and those who were in attendance for the inspection, spoke confidently about the individual assessed needs of each resident. There was a large emphasis within this centre to ensure residents were supported by an adequate number of staff, that they were maintained safe from harm, and that any change in their assessed needs was quickly identified and responded well to. However, there were key aspects of this service that required significant attention by the provider, to ensure better oversight and monitoring arrangements were in place, to identify and respond to areas of improvement that needed addressing.

The specific findings of this inspection will now be discussed in the next two sections of this report.

Capacity and capability

Following on from the findings of the last inspection of this centre in January 2023, the provider improved residents' personal planning and assessment arrangements and fire evacuation, and had ensured that these improvements were sustained. The provider had also made improvements to risk and governance and management, fire precautions and behavioural support. Although these improvements were evident on this inspection, some of these areas still required further review, with more significant improvements required to aspects of medication management practices and safeguarding.

The provider had monitoring arrangements in place to oversee the quality and safety of care in this centre, which reviewed a wide range of care and support practices. However, some were not robust enough to identify where specific improvements were required in this particular centre. This was particularly found in

relation to medication management, where, medication audits that were being completed regularly, failed to identify a prescribing error, that was identified on this inspection, resulting in an immediate action being issued to the provider to address. Furthermore, there were failings also found in relation to the oversight of safeguarding processes, to ensure all concerns were reported to the designated officer. These were two key areas of practice in this centre, which were subject to regular auditing and review; however, the provider's own monitoring systems had not been effective in detecting these particular issues, that were raised by inspectors.

The person in charge held a full-time role and was based at the centre, and was supported by a team leader. They both held an administrative and direct care role, which was an arrangement that worked well in this house. There was regular communication between local management and staff, and the person in charge was also on frequent contact with their line manager. The person participating in management was newly appointed to the role for this service in recent months, and had completed much work with the person in charge in relation to restrictive practices, which was evident from the findings of this inspection.

Due to the high support needs that some residents had, staffing levels were maintained under very regular review. Three-to-four staff were rostered each day, with one staff member on waking duty each night. One-to-one staff support was provided to residents who were assessed as requiring this level of support, which was reported to be working well. Local management recognised the importance of staff consistency in this centre, and had a panel of relief staff who were familiar with the residents and the service, available to support this centre's staffing arrangement, as and when required.

Registration Regulation 5: Application for registration or renewal of registration

Prior to this inspection, the provider had satisfactorily submitted an application to renew the registration of this centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge held a full-time role and was based at the centre. They were supported in their role by a team leader, their staff team, and line manager in the running and management of the service. They had good knowledge of the residents' assessed needs, and of the operational needs of the service delivered to them. This was the only designated centre operated by this provider in which they were responsible for.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangement for this centre was subject to on-going review, ensuring a suitable number and skill-mix of staff were at all times on duty. Where additional resources were required from time to time, the provider had arrangements in place for this. There was also a well-maintained staff roster in the centre, which clearly outlined each staff members name, and their start and finish times worked.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had effective staff training arrangements in place, ensuring that all staff had received the training that they required to carry out their duties. Where refresher training was required, this was scheduled accordingly. Each staff member was also subject to regular supervision from their line manager.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured this centre was adequately resourced to meet the assessed needs of the residents, and that suitable persons were appointed to manage and oversee the running of the service. There were also good internal communication systems in place, whereby, the person in charge held regular meetings with their staff team, attended management meetings, and also maintained regular contact with their line manager about operational matters. A six monthly provider-led visit was completed a few months prior to this inspection, with all identified actions having being rectified. In addition to this, a number of internal audits were being completed to oversee areas such as finances, personal planning and medication management. However, a review of these monitoring systems was required to ensure these were effective in identifying where specific improvements were required to this service, particularly in relation to medication management and safeguarding.

During a review of medication management by inspectors, an immediate action was required to be issued to the provider in relation to prescribing practices. This was rectified by those who facilitated this inspection; however, this was an aspect of

service that was subject to very regular review by the provider, who had not detected this issue for themselves, using their own monitoring processes, prior to it being brought to their attention on this inspection.

The second aspect of service that this inspection identified required significant improvement was the oversight of aspects of safeguarding processes. Although there was a good local response to when safeguarding concerns were raised, the provider had failed to identify a gap in the implementation of their own processes, in the reporting of a safeguarding concern to the designated officer. Again, this was another area of service that was subject to on-going review; however, such reviews had been ineffective to identify this failing, prior to this inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

Where incidents occurred in this centre, the person in charge had a system in place to ensure these were recorded, reported, reviewed and responded to. They had also ensured that all incidents were notified to the Chief Inspector of Social Services, as required by the regulations.

Judgment: Compliant

Quality and safety

Inspectors found that in many regards, the quality and safety of care was held to good standard. Residents were supported by comprehensive assessment and personal planning of their care and support needs, and received good support from staff in relation to managing their personal finances. Although these were positive examples of good care practices, inspectors also found that significant improvements were required in regards to safeguarding and medication practices.

Medication practices were subject to regular auditing, and any errors identified through this process were reported and responded to, using the provider's incident reporting system. However, upon review of a resident's medication prescribing records, an inspector observed a medication error, relating to prescribing practices, which had not already been identified by the provider, through their own monitoring systems. This was brought to the attention of those facilitating the inspection, and an immediate action was issued to have it rectified.

The safeguarding of residents is an integral aspect of care, that ensures that residents are safe and have a good quality of life. The provider had a safeguarding policy and procedures to safeguard residents in this centre. In addition, a person

had been nominated to investigate any allegations of abuse, and this person was known to the staff team and residents, as they had recently visited the centre to discuss safeguarding with both parties. Although these arrangements were in place, inspectors found that significant improvements in regards to safeguarding were required. For example, a recent issue which had been identified as a safeguarding concern had not been referred to the nominated person for investigation. In addition, staff had been advised to refer to a safeguarding plan for guidance, however, this plan had not been updated since 2019, and failed to account for a recent safeguarding incident.

Fire safety arrangements were maintained under very regular review, and a number of fire drills occurred to assess if staff could support these residents to safely evacuate. Records of the four of the most recently completed fire drills were reviewed by inspectors, which demonstrated a good response to evacuation. However, a review of some residents' evacuation plans were required, as some of these included the use of restrictive practices, in order to support these residents to evacuate, with little evidence to demonstrate that alternative methods of evacuation had been explored and trialled.

Although improvements were required to safeguarding and medication management, residents did enjoy a good quality of life, and they were well supported to engage in activities which they enjoyed. Inspectors met with two residents when they returned from day services and they both appeared happy upon the return, and both interacted warmly with staff who were on duty. A review of records showed that residents had good access to their local community and often went to the local shops, cafes and restaurants. A review of residents' personal plans, showed that a resident had been supported to attend a family member's wedding and also how they enjoyed suit shopping for the event. Photographs from the day showed how proud the resident was of their appearance, and also the fun which they had with their family on the day. In addition, the resident's family had contacted the centre to thank them for the support which the resident received in preparing for the big day.

Regulation 12: Personal possessions

Residents had their own bedrooms, each of which had ample storage for their clothes and personal possessions. In recent times, a resident had entered another resident's bedroom without their permission and had damaged an item of clothing. This issue was taken seriously by the provider, and the safeguarding plan was implemented to prevent against re-occurrence.

Residents who used this service, required support in paying for goods and services, and also with managing their finances. Two residents had their own bank accounts while other residents had support from their respective families. A senior staff on duty, showed an inspector how residents were supported with cash and cashless transactions. Detailed financial records were maintained and the review of these

records showed that receipts were in place for all residents' spending. The senior staff member also completed regular audits and reviews of both spending and associated receipts, which also promoted the safeguarding of residents' finances and possessions.

Judgment: Compliant

Regulation 17: Premises

This designated centre comprised of one large bungalow dwelling. The house was clean, spacious and comfortably furnished. Where residents responded well to minimal furnishings, this was respected and their bedrooms were decorated in such a manner. At the time of this inspection, the provider was in the process of upgrading the kitchen and laundry room, was planning to install new wardrobes to bedrooms, and had also identified a number of redecoration and repair works to various communal areas. These works were well recognised by local management, and had been requested by them via the provider's maintenance request system, to be completed. At the time of this inspection, members of local management were awaiting a date for when these works would be commencing. In the interim, all other repair and maintenance works were being reported, and quickly rectified as part of the provider's maintenance system for the service.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems in place for the identification, response, assessment and monitoring of risk in this centre. Following on from the last inspection of this centre in January 2023, the provider had rectified the issues raised with regards to risk management, which included, better arrangements to support staff during out of hours, and ensuring the person in charge received adequate training and guidance appropriate to their role. The last inspection of this centre identified that improvements were required to centre's risk register, and although there was evidence that this document was subject to on-going review, aspects of the register didn't reflect the current monitoring and oversight of some specific risks relating to this service.

The risk register was maintained under regular review by the person in charge and contained various risk assessments pertaining to this centre. However, some required review to ensure they adequately reflected the specific hazards that were identified, and the control measures that were put in place to mitigate against them. This was particularly observed within the risk assessments in place for fire safety and medication management, which didn't reflect the current status of risk

pertaining to these aspects of service.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had effective fire safety arrangements in place, to include, detection and containment systems, emergency lighting was available, all staff had up-to-date training in fire safety, and regular fire safety checks were being conducted by staff.

Following on from the outcome of the last inspection, the provider had revised their fire procedure for the centre and had carried out a number of fire drills, with the records of these giving assurances that staff could support these residents to evacuate the centre in a timely manner. However, a review of how some residents were being evacuated required review, to ensure the most effective evacuation method had been explored for each resident. For example, for two particular residents, the use of restrictive practices was required in order to support them to leave the centre. However, the provider had not explored alternative evacuation methods that could be implemented, to see if these would be an effective form of evacuation for these particular residents.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Although the provider had medication management procedures available at this centre, significant improvement was required to ensure these were being appropriately implemented in this centre.

Upon review of a resident's prescription record, inspectors found that the dose of one particular medicine was not clearly prescribed. This was then corresponded with the resident's blister pack, and although there was information provided with this blister to identify each individual medicine in the blister pack, inspectors and the person in charge were unable to confidently identify all medicines dispensed within the night-time blister. An immediate action was given to the provider to review, and this was rectified the evening of this inspection.

Although medication management was an area of this service which was subject to regular auditing, this had not resulted in this medication error being identified, prior to this inspection. In the weeks prior to this inspection, a new medication audit tool had been implemented by the provider. A template of this audit tool was reviewed by inspectors and although it did look at various aspects of medication management, it didn't allow for specific medication prescribing and medications

practices relevant to this centre, to be reviewed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had comprehensive personal plans in place, which were reviewed on at least an annual basis, so as to reflect changes in regards to their individual care needs. An inspector reviewed three residents personal plans and found that they were individualised and give a good account of residents' support needs, and guidance on how they preferred to have their care delivered.

Residents were also supported to identify and achieve personal goals. They attended their annual individual planning meeting and were supported by their family key workers and staff members from their day services. At this meeting, residents decided on their goals and their support staff implemented action plans to support them. The inspector reviewed plans which showed that residents had attended football matches, attended a friend's 60th birthday, redecorated their bedroom and also went to see the Irish rugby team.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behaviour support was a key function in the delivery of care in this designated centre. Two residents in particular, who used the service, had complex needs in terms of behaviour support. Two staff who met with an inspector had in-depth knowledge of both residents behaviour needs. They explained in great detail, both the proactive and reactive strategies, which were in place to support both residents during periods when they were at baseline, and also as their behaviours escalated. There was also a high number of restrictive practices in use in this centre, which were assessed as being required, in accordance with residents' assessed needs. These were maintained under regular review, and had been subject to much recent improvements, which were made by the person in charge and person participating in management.

An inspector reviewed both behavioural support plans on the day of inspection, and found that both documents give a good account of residents' behaviours and recommended interventions. Although the inspector found that staff had good knowledge of behavioural support, their knowledge base was not reflected in the associated positive behaviour support plans which were reviewed. For example, both plans failed to identify recommended staffing ratios, and one plan did not include a key trigger for the escalation of their behaviours. In addition, the second behaviour

support plan did not clearly outline how supporting the resident with various activities, had been found to be a stressor for them. Furthermore, the plan failed to detail that staff had returned to less stressful community activities in order to improve the resident's quality of life.

It was clear that staff knew how to support residents with the behavioural needs, however, improvements were required to both behavioural support plans to ensure that a consistent approach was offered to both residents in this centre.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding residents is a fundamental component of care and a core responsibility of the registered provider. In this centre, there were four active safeguarding plans on the day of inspection. These plans were primarily put in place following negative interactions between residents, and aimed to keep residents safe from harm.

One inspector examined safeguarding arrangements in the centre. Two safeguarding plans were reviewed, and the person in charge and a staff member explained how safeguarding was promoted in the centre. The inspector found that improvements were required in regards to both safeguarding plans. Furthermore a recent safeguarding incident had not been referred to the provider's designated officer, as required, and no arrangements had been put in place to safeguard the resident who was directly affected by this incident in this centre.

In regards to the safeguarding plans, one plan did not contain an accurate reflection of the resident's individualised staffing arrangements, and required further review. Significant improvements were also required in regards to the second safeguarding plan. For example, the provider's designated officer had visited the centre following a safeguarding concern. The advice from the designated officer was to follow a safeguarding plan which was in place since 2019 and upon review, the inspector found that this plan had no relevant information in regards to the recent safeguarding incident.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' individual preferences, capacities and assessed needs were well-known in this centre, and guided how the service operated on a daily basis. Residents were regularly engaged with about the care and support that they received, and all efforts were made by staff to provide them with meaningful interactions, and activities that

they were known to respond well to. Their right to be involved in their care was promoted, with due consideration given to their communication needs, when involving them in this process. Residents' rights was a topic that was regularly discussed with staff, and any incidents impacting residents' right to privacy and dignity was promptly responded to by the provider.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Grange View Services OSV-0004063

Inspection ID: MON-0041326

Date of inspection: 27/05/2024

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Immediate action taken on day of inspection to correct error noted. Person in Charge met with Pharmacist and Cardex amended as required.
Person in Charge and Team Leader completed full review of medication to ensure no other errors present. This was completed 28/05/2024.
Person in Charge and Team Leader discussed management audit tools and amended internal audit system to ensure that errors are noted and addressed in a timely manner. This includes safeguarding audit on a monthly basis.
Full medication audit to be carried out by a Nurse in Ability West. This will be completed by 20/06/2024.
Area Service Manager, Person in Charge and Team Lead had a meeting on 17/06/2024 to discuss oversight of medication management and the auditing system within the service. Area Service Manager, Person in Charge and Team Lead to review medication at Service review meetings. These will be held monthly until September to ensure internal audits are effective and actions addressed. Medication Management will be an agenda item at monthly staff meetings, commencing on 19/06/2024.

Person in Charge followed up with Designated Officer 28/05/2024 in relation to a particular incident. Area Service Manager, Person in Charge and Team Lead met 17/06/2024 to discuss oversight of safeguarding concerns within the service and actions identified. Audit of safeguarding queries and concerns will commence 26/06/2024 and will continue monthly to ensure that internal safeguarding processes are being followed and ahered too. Safeguarding processes will be discussed as an agenda item at team meetings commencing 19/06/2024 and will continue monthly.
Person in Charge and Team Lead to attend HIQA webinar 28/06/2024 on safeguarding regulatory practices.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk register has been fully reviewed by the Person in Charge and Team Lead to ensure that each risk adequately reflects the hazards in the service. This was completed 12/06/2024. The risk register will be reviewed by the Area Service Manager at each Service Review, which will be held monthly within the centre.

All risk assessments, associated with the risk register will be reviewed and any amendments completed by 27/06/2024.

Risk Management will be discussed at a team meeting on 19/06/2024 and will continue to be an agenda item at monthly team meetings.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
PEEP for one resident and CEEP updated to ensure a quicker evacuation time in the event of a fire, particularly at night time. This was completed 17/06/2024.

PEEP for another resident and CEEP reviewed and amended. Alternative evacuation methods discussed and evacuation trialed with changes noted. This was completed on the 11/06/2024. Outcome of this fire drill discussed with Area Service Manager on 17/06/2024.

Changes to PEEPs & CEEPs discussed at staff meeting on 19/06/2024.

All restrictive practice referrals in relation to fire evacuation will be submitted to the Restrictive Practice Committee by 24/06/2024.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Immediate action taken on day of inspection to correct error noted. Person in Charge met with Pharmacist and Cardex amended as required.
Person in Charge and Team Leader completed full review of medication to ensure no other errors present. This was completed 28/05/2024.
Person in Charge and Team Leader discussed management audit tools and amended internal audit system to ensure that errors are noted and addressed in a timely manner. Full medication audit to be carried out by a Nurse in Ability West. This will be completed by 20/06/2024.
Area Service Manager, Person in Charge and Team Lead had a meeting on 17/06/2024 to discuss oversight of medication management and the auditing system within the service. Area Service Manager, Person in Charge and Team Lead to review medication at Service review meetings. These will be held monthly until September to ensure internal audits are effective and actions addressed. Medication Management will be an agenda item at monthly staff meetings, commencing on 19/06/2024.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Positive Behaviour Spport plan for one resident updated at local level by the Person in Charge and Team Lead to clearly outline the resident's daily supports. This was completed 19/06/2024, following discussion at staff meeting on 19/06/2024.

Person in Charge and Team Lead will meet Psychology on 03/07/2024 to review and update the Positive Behaviour Support Plan for another resident to ensure it reflects the resident's supports needs.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Person in Charge followed up with Designated Officer 28/05/2024 in relation to a particular incident.
All Safeguarding plans will be reviewed by the Person in Charge and Team Lead to ensure they are reflective of required staffing arrangements. Any amendments will be discussed with the Head of Social Work.
Area Service Manager, Person in Charge and Team Lead met 17/06/2024 to discuss

oversight of safeguarding concerns within the service and actions identified. Audit of safeguarding queries and concerns will commence 26/06/2024 and will continue monthly to ensure that internal safeguarding processes are being followed and ahered too.
Safeguarding processes will be discussed as an agenda item at team meetings commencing 19/06/2024 and will continue monthly.
Person in Charge and Team Lead to attend HIQA webinar 28/06/2024 on safeguarding regulatory practices.

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.	Not Compliant	Orange	28/06/2024
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	27/06/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	24/06/2024

	evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Red	20/06/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	03/07/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/05/2024
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any	Not Compliant	Orange	28/06/2024

	incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			