Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Mixed).

Issued by the Chief Inspector

Name of designated centre:	Ard Na Gaoithe
Name of provider:	Resilience Healthcare Limited
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	15 November 2024
Centre ID:	OSV-0005335
Fieldwork ID:	MON-0038106

About the designated centre

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

Ard na Gaoithe provides a residential service to children and young adults with a diagnosis of an intellectual disability, autistic spectrum disorder and behaviours. The objective of the service, as set out by the statement of purpose, is to provide a high standard of care in a living environment that replicates a natural home environment. The centre can accommodate a maximum of four residents at any one time aged from 15 to 21 years of age and these can be male or female. The service is open seven days a week and the young people are supported by a team of support workers and a management team. A behavioural specialist is available to support staff in their care of the children. The centre is a four-bedroomed bungalow based in a rural location. Vehicle access is provided to enable residents to access local amenities, school and leisure facilities. There is a large garden available to the residents with play equipment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 15 November 2024	08:50hrs to 17:00hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed, residents in this centre continued to be offered a person centred service, tailored to their individual needs and preferences. Residents were seen to be provided with opportunities to take part in activity and there was ongoing consideration of residents changing needs as they transitioned into adulthood. Overall, the evidence indicated that this was a well run centre. An issue identified in relation to the oversight of medication practices in the centre was identified and some premises issues were noted.

This centre comprises a large detached dormer bungalow located in a rural area. The premises is subdivided into a three bedroom house and a one bedroom interconnected apartment space. An office, staff bathroom, and storage space occupy the upstairs part of the house and resident accommodation is provided on the ground floor. There are two large secure garden areas available to residents, including a dedicated garden area for the resident living in the apartment. The centre was fully occupied at the time of this inspection and there had been no change in the resident cohort since the previous inspection. This centre accommodated teenagers and young adults and was transitioning to an adult service as the current residents aged in place. All of the residents availed of full-time residential services. The main house accommodated three residents on the ground floor and the apartment is home to one resident.

Overall, the inspector saw that there were ongoing efforts to ensure that the centre was well maintained and appropriate to the needs of the residents living there. Some paintwork and other minor repairs had been completed since the previous inspection. At the time of this inspection, preparations were underway to complete some upgrading and renovation works to the centre that would provide for enhanced facilities for residents. Since the previous inspection, the provider had changed some of the plans outlined during that inspection and now intended to refurbish the present centre but not extend or increase the capacity of the centre. Some additional parking facilities were still planned also to safely accommodate the volume of vehicles that were present when the full staff and management complement were present in the centre. An electric vehicle charging point was also planned.

One resident continued to occupy an annex apartment attached to the main building. This annex apartment had a separate entrance and its own entrance and garden area, and could also be accessed via a door from the main house. This resident required a minimalistic environment. It was seen that efforts had been made to decorate this space in line with the preferences and assessed needs of the resident living there.

Overall, the inspector saw that ongoing efforts were being made to provide a homely environment for residents, that was also in line with residents' assessed needs. Residents' bedrooms were seen to be personalised and there were a number

of separate areas where residents could relax and spend time apart from the other residents if they wished. A number of televisions were available to residents and there was a trampoline available for the use of the resident that occupied the apartment space. Numerous photographs and canvases were displayed of residents enjoying activities.

The inspector had an opportunity to meet with and spend time observing all of the residents of this centre at different times of the day. Some residents chose to interact with the inspector and some chose not to and residents wishes were respected in this. Residents were provided with day service activities in the centre and the inspector was told that this was provided in line with New Directions. Residents were observed leaving and returning to the centre for community based activities during the day and to spend time in the centre for periods.

The inspector observed a number of interactions between staff and residents that indicated that residents were comfortable with the staff that supported them. Residents were observed to move freely about their home and to spend times in preferred areas. Residents were observed eating freshly prepared snacks and meals and staff were seen to be familiar with how residents communicated their preferences and to support residents in a respectful manner. Personal care was offered in a discreet and dignified manner and staff were seen to respond quickly to a resident who was indicating discomfort and provide pain relief promptly.

The inspector spoke with two staff privately and a number of other staff during observations in the centre. Staff reported that they felt residents were safe and well cared for in the centre and that the provider was responsive to any issues or concerns raised. Staff spoken with told the inspector that they would be comfortable to raise concerns, including safeguarding concerns or complaints. Staff also spoke about recent supervision meetings they had taken part in and were positive about the training provided to them to support them in their roles.

The inspector was also provided with two questionnaires completed by family members on behalf of their relatives prior to the inspection. The annual review also contained details about resident and family consultation completed by the provider. These contained positive responses about the care and support received in the centre and the services and facilities available to them. There were no visitors in the centre on the day of the inspection and the inspector did not meet with any family members during this inspection.

Overall, the findings on this inspection indicated that residents were afforded a good quality of life in this centre and there was good compliance with the regulations. The next two sections of the report present 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 service being delivered.

Capacity and capability

The findings of this inspection showed that the management systems in place in this centre were ensuring that good quality services were being provided to the residents. This inspection found that overall there was good evidence of compliance with the regulations. Although action had been taken since the previous inspection to address some issues found in the area of medication management, a further issue was identified in relation to the recording of controlled medications administered in the centre.

There was a clear management structure present and there was evidence that the management of this centre were maintaining good oversight and maintained a strong presence in the centre. There had been a change in the local management of the centre since the previous inspection. The person in charge had departed the role and this position had been filled by another individual on an interim basis. At the time of this inspection a new person in charge had been appointed by the provider and had commenced working in the centre. The incoming person in charge was supported by a full-time team leader in the centre to provide local oversight and governance. The person in charge reported to a regional manager, who was also a named person participating in the management of the centre (PPIM). All three of these individuals were present on the day of the inspection and spoke with the inspector.

The team leader had worked in the centre since it had opened and was very familiar with all of the residents living in the centre. The person in charge was also seen to be knowledgeable about the residents, and it was evident that they had made significant efforts to become familiar with residents and their assessed needs in the short time they had occupied the role. The PPIM reported to the director of social care, who reported to a Chief Executive Officer (CEO) and a Board of Directors.

This was an announced inspection to assess ongoing compliance with the regulations and inform the upcoming decision in relation to the renewal of the registration of the centre. The previous inspection of this centre was completed in August 2023 with very good findings overall. At that time, the provider indicated that they were planning some building works to change the layout of the centre. Since then, some further work had been undertaken to assess the suitability of this plan and some changes had been made to the plans in place to reduce the impact any works would have on the residents living in the centre. The inspector viewed the plans for the proposed adaptations to the centre and this included a schedule of works. The provider intended to replace all of the fire doors in the house during these works also. The inspector was told that these works were due to commence in early 2025.

Documentation reviewed during the inspection included resident information, the annual review, the report of the unannounced six-monthly provider visit, audit schedule, incident reports and team meeting minutes. There was evidence that the provider was identifying issues and taking action in response to them. The most recent six monthly unannounced visit completed by a representative of the provider had taken place in September 2024 and some actions identified in these were seen

to have been completed such as the updating of out-of-date policies.

The management team were familiar with the assessed needs of residents and knowledgeable about all aspects of the care and support residents received in the centre. The centre was seen to be well resourced and staffing levels were seen to provide for a good quality and personalised service. Staff were appropriately trained and reported that the provider was responsive to any issues or concerns raised. Overall, a consistent staff team supported residents and a number of staff had worked in the centre for a number of years.

Overall, this inspection found that there was evidence of continued good compliance with the regulations in this centre and that residents were being afforded safe and person centred services. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 14: Persons in charge

The registered provider had recently appointed a new person in charge. This person possessed the required qualifications, experience and skills for the role. At the time of the inspection this individual had remit over two linked designated centre, and at the time of this inspection they presented to have the capacity to maintain good oversight of the centre. Evidence of the person's qualifications, experience and skills was submitted by the provider and was reviewed by the inspector prior to this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The training needs of staff were being appropriately considered. The inspector viewed a training matrix for twenty three staff that were also named on the centre roster. This matrix showed that staff were provided with training appropriate to their roles and that the person in charge had oversight of the training needs of staff. Mandatory training provided included training in the areas of medication management, fire safety and safeguarding of vulnerable adults. Where training was due to be completed this had been booked.

A supervision schedule was in place that showed all staff were receiving formal supervision on a regular basis and since commencing in the centre the incoming person in charge had met with some staff for formal supervision and had scheduled this for all staff.

Judgment: Compliant

Regulation 22: Insurance

The provider had in place insurance in respect of the designated centre as appropriate. An insurance certificate dated to July 2025 was viewed in the centre.

Judgment: Compliant

Regulation 23: Governance and management

This inspection found that the provider was ensuring that this designated centre was adequately resourced to provide for the effective delivery of care and support in accordance with the statement of purpose. Management systems were in place that overall ensured that the service provided was appropriate to residents' needs. Documentation reviewed by the inspector during the inspection such as provider audits, team meeting minutes, the annual review, and the provider's report of the most recent six monthly unannounced inspection, showed that the provider was maintaining oversight of the service provided in this centre and that governance and management arrangements in the centre were generally effective.

There was a clear governance structure in place and the centre was adequately resourced to provide a good quality service to residents. The local management team, consisting of the person in charge and a team leader, were seen to have the capacity to maintain good oversight of this centre. Staff spoke with the inspector and reported that they felt comfortable to raise concerns and that issues raised were taken seriously and responded to by the management of the centre. Staff were aware of the reporting structures in place.

Since the previous inspection, there had been two changes to the person in charge appointed to the centre. The presence of an experienced and familiar team leader in the centre had meant that the impact of these management changes was reduced. A new person in charge had recently been appointed to oversee the day-to-day management of the centre. This individual had commenced the role in the weeks prior to this inspection and was met with during this inspection. They were found to be developing a strong knowledge base about the residents and their support needs and to already maintain a strong presence in the centre. The remit of the PPIM had also decreased in recent months and they reported to the inspector that this meant that they had more time to dedicate to the individual centres under their remit.

Unannounced six-monthly visits were being conducted by a representative of the provider and the written report of the most recent of these was reviewed by the inspector. There was an action plan arising from these visits to record issues identified and the documentation in place demonstrated that the provider was taking

action to address identified issues. An annual review had been completed in respect of the centre and this included details of consultation with family members and representatives of residents about the care and support being offered in the centre.

However, further oversight of staff practice in relation to the management of medications was required to ensure that staff fully implemented the providers' policy in relation to the safe administration of medication. The inspector reviewed the records kept in relation to the administration of the controlled medications in the centre for the previous month and saw that overall the controlled drugs register was being maintained. The inspector saw that a controlled medication had been recorded as administered to a resident on the morning of the inspection and a count of medications completed by the team leader in the presence of the inspector indicated that this was correct. However, the controlled drugs register had not been updated to reflect this and this did not provide assurance that staff had completed a stock check prior to and following the administration of this medication. This was not in line with the providers Safe Administration of Medication policy which outlined that these checks should be completed prior to, and following, the administration of controlled drugs the Drug Stock Control Record and the MDA drug register should be updated. This documentation error was responded to immediately once the inspector brought it to the attention of the management of the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had in place a statement of purpose that contained all of the information as specified in the regulations. This was reviewed by the inspector prior to the inspection. A minor amendment was required to ensure that all of the information contained in the statement of purpose was fully accurate following the change of the person in charge and this was addressed at the time of the inspection.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints policy and procedure. Information about making a complaint was viewed on display in the front hallway of the centre, including details of the complaints officer.

A complaints log was reviewed by the inspector for the designated centre. It was seen that complaints were recorded as appropriate in this log. There were no open complaints recorded at the time of this inspection. A previous complaint had been

logged from a social worker for a resident concerning the accuracy of some documentation in the centre. A number of actions had been taken following this to respond to the complaint and this was recorded as resolved to the satisfaction of the complainant.

Staff were familiar with the complaints procedures in the centre and told the inspector about how they would respond to complaints received in the centre. It would be difficult for some residents living in the centre to independently make a complaint and staff that spoke to the inspector told the inspector that they would be comfortable to support a resident to make a complaint if required.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had in place written policies and procedures in relation to the matter set out in Schedule 5 and these were kept in the centre and available to staff. The inspector was provided with a folder containing the centres' policies and procedures during the inspection and reviewed a sample of these. The policies viewed were up-to-date and had been reviewed within the previous three years as required by the regulations.

Judgment: Compliant

Quality and safety

The wellbeing and welfare of residents in this centre was maintained by a very good standard of evidence-based care and support. Findings of this inspection indicated that safe and good quality services were provided to the four residents that lived in this centre and that the services provided were in line with the assessed needs of residents.

Staff spoke respectfully about residents and told the inspector about why they felt residents had a good quality of life in the centre. Staff spoke about the various ways in which residents were offered choices and how residents communicated preferences. Staff were seen to be committed to the residents that they supported and warm interactions were observed by the inspector during the inspection. Residents were observed to be content and happy in their home.

The residents in the centre were supported by a familiar and consistent staff team who were seen to be responsive to the residents needs and familiar with their the care plans and positive behaviour supports in place for residents. Overall a low turnover of staff was reported and there were no agency staff working in the centre

at the time of the inspection which offered consistency of care and support to residents. The staff team observed on the day of the inspection presented as committed to supporting residents in a manner that best met their individual needs.

Usually six staff worked in the centre by day. One to two staff supported each resident by day and two waking staff were available by night to support all four residents. There were three vehicles available to residents also. This meant that residents had opportunities to take part in community based activities very regularly.

Resident information viewed indicated that residents were supported to access healthcare and medical services if required. A resident had received a dental review under sedation. Plans had been put in place to carry out other necessary interventions, such as cleaning their teeth and blood tests while the resident was sedated to minimise the potential for causing distress to the individual.

As seen on the previous inspection, there were some restrictions in place for some residents due to their assessed needs and for health and safety reasons. Overall, these appeared to have been considered and put in place in a manner that would have the least impact on residents.

The inspector viewed a number of documents throughout the day of the inspection, including a sample of residents' most recent assessments of need, person centred plans, support plans, medication management records and positive behaviour support guidance. The documentation viewed was seen to be well maintained and provide information about residents that was up-to-date and person-focused.

Regulation 13: General welfare and development

The registered provider was providing each resident with appropriate care and support and providing access to facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. The registered provider was ensuring that the young person and adults living in the centre had opportunities for play and activity, age appropriate opportunities to be alone; and opportunities to develop life skills.

Residents were supported to attend various external activities including equine therapy, the cinema, community events, beach trips, sporting activities & social activities. The documentation viewed for one resident showed that they had taken part in holiday celebrations such as an Easter Egg Hunt and a Halloween party.

Residents were supported with learning and developing life skills in the centre also. Life skills activities were recorded and goals were set monthly in relation to the life skills that residents were working on. These included supporting residents to become more independent in activities of daily living such as money management, basic laundry tasks, and personal care activities.

Residents were supported to maintain and develop important personal relationships

and contact with important people in their lives, such as parents and siblings. For example, a number of resident had younger siblings and the inspector was told that three of the residents and their families had recently taken part in a group outing to the pantomine and this had been very successful. One resident was facilitated to go home every weekend for a period.

The provider had made arrangements that allowed for residents to remain in their home as they transitioned into adulthood and this was providing consistency for the residents.

Judgment: Compliant

Regulation 17: Premises

The registered provider was taking steps to ensure that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents on an ongoing basis. Building works were planned to commence in January 2025 that would provide for additional and enhanced bathroom facilities and safer parking facilities in the centre. A walk around of the premises was completed by the inspector. The premises was seen to be well overall adequately maintained and of a suitable size to meet the needs of the four residents that lived there at the time of the inspection, although it was evident that residents in the main house would benefit from additional bathroom facilities.

Resident bedrooms and living areas were seen to be decorated in a manner that reflected the resident cohort living in the centre. Bedrooms were personalised according to residents' tastes. For example, one residents' room was decorated with fairy lights and pretty soft furnishings. Overall, the centre was observed to be clean on the day of the inspection. There were outdoor areas available for the use of residents. Laundry facilities were provided in a separate utility room.

Some outstanding maintenance issues were identified such as some areas internally that required painting and refurbishment. Some areas of the external premises required some maintenance also. For example, the front garden area required some attention and a fence was seen to require painting. Some of these issues had been highlighted also in previous inspections. The inspector was informed that this work would all be completed at the same time as the planned building works were being completed.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed the management of medications in the centre, including the records kept in respect of medications administered and stored in the centre. A medication policy was in place and this had been last reviewed by the provider in October 2024.

PRN (medication given as required) protocols were viewed to be in place in residents' medication folders. These provided guidance to staff about the indications for use for these medications, the maximum dosage to be administered, the minimum interval between doses and administration instructions. A sample of these were reviewed for a resident and were seen to provide clear guidance to staff. A protocol was seen to be in place for each PRN medication the resident was prescribed.

The storage of medications in the centre had been reviewed by the provider since the previous inspection and the inspector observed more robust practices in place in relation to this. The shift leader now held the keys for the medication presses and these were observed to be kept locked as appropriate throughout the inspection. The inspector reviewed two residents medication presses and saw that medications available to residents was in line with the drug prescription records kept for each resident. Medication administration records indicated that residents received medications as prescribed. Medications stored in the residents' medication presses was seen to be labelled and in-date and there were separate storage facilities for pharmacy returns. A medication count was completed daily and a three week sample of records was reviewed for a resident. This document also recorded the expiry dates of the medications in stock. A weekly check of medication balances was completed by the team leader and this contributed to the oversight of medications in the centre. Each residents medications were stored separately and there was a double locking system in place for controlled medications. A documentation oversight in relation to medications has been addressed under Regulation 4: Written policies and procedures.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that an annual needs assessment had been completed for residents and the registered provider had arrangements in place to meet the assessed needs of the residents living in this centre. The person in charge had ensured that personal plans were in place residents that reflected their assessed needs, outlined the supports required to maximise residents' personal development in accordance with their wishes, age and nature of their disability. Personal plans were subject of a review, carried out annually or as changing circumstances required.

A sample of two residents' files were reviewed during this inspection. Assessments of need had been reviewed within the previous year and these informed the

individual support plans in place for residents. Support plans were in place that provided good guidance to staff about the supports residents required to meet their healthcare, social and personal needs. An annual person centred planning meeting was documented in each residents file. The inspector saw that goal planning was documented in the centre and that residents were being afforded opportunities to set and achieve goals. The management of the centre told the inspector that there was a plan to work with staff in the centre to further develop the goals being set for residents as they completed their transitions into adulthood.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff had up to date knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour. Procedures and practice guidelines were in place to guide staff and a restricitve practice policy was also in place.

Individualised risk assessments were viewed in residents' files and where required protocols were in place to address specific risks, including risks arising from the responsive behaviours of residents. For example, the inspector viewed protocols in place regarding choking, self injurious behaviours and PICA. There were also protocols in place around the use of seclusion and physical holds for one resident who occasionally engaged in responsive behaviours that might at times be a risk to other residents or staff. The protocols in place clearly outlined when these practices should be used, what staff should try prior to using them and that they should be in place and for the minimum duration necessary.

Residents had positive behaviour support plans in place. The inspector reviewed the plans in place for two resident who presented with specific needs in this area. These had been reviewed regularly and were put in place with the support of the providers behaviour support specialist. This plans provided good guidance for staff and showed that the input of other allied health professionals was also received. For example, an occupational therapist had been engaged to support the residents with specific sensory needs and residents took part in equine therapy to support identified needs in that area. Specific recommendations had been made for one resident in relation to trialling different sensory equipment and strategies and it was documented which of these had been trialled and how the resident responded to these. Staff were observed to respond appropriately to residents and adhere to the plans in place during this inspection.

In late 2023 and early 2024 another resident had experienced an unsettled period, with a noted increase in responsive behaviours. Records viewed in this residents file showed that during this period they had been reviewed very regularly by a psychiatrist, and their medications had been reviewed.

Judgment: Compliant

Regulation 8: Protection

A Safeguarding Children policy was viewed to be in place and had last been reviewed by the provider in December 2023. A Safeguarding Vulnerable Persons policy was also viewed that had been reviewed by the provider in September 2024.

The inspector reviewed the records relating to the Garda vetting of the staff working in the centre and saw that all staff named on the staff roster had been appropriately vetted. As per the providers' policy, Garda vetting disclosures were obtained for staff every three years. The inspector viewed evidence that showed that the human resources department had applied for renewed disclosures in respect of a number of staff who were last vetted in late 2021.

Very few notifications of a safeguarding nature had been submitted to the Chief Inspector from this centre since the previous inspection and the evidence reviewed on this inspection indicated that overall residents living in the centre were compatible and did not negatively impact on one another. However, a notification received from the centre indicated that some staff-related issues had potentially impacted residents indirectly. The inspector reviewed the actions taken in response to this incident and saw that the provider had responded and taken actions to protect residents in their home and prevent a reoccurance. For example, a rolling roster had been introduced and this was reported to be working well.

Judgment: Compliant

Regulation 9: Residents' rights

The findings of this inspection indicated that residents' rights were considered and respected in this centre.The registered provider was ensuring that efforts were being made to ensure that each resident had the freedom to exercise choice and control in his or her daily life. Insofar as possible, and in line with their communication needs and preferences, residents were seen to be supported to exercise choice and control in their daily lives and to participate in decisions about their own care and support. Staff were observed to take time to determine residents' preferences and choices where possible, and to support residents in a manner that respected their individual communication styles.

One resident, who had transitioned into adulthood since the previous inspection had been supported to access legal and court services in relation to assisted decision making and the service was supporting access to their appointed decision maker. The inspector viewed some documentation in place in this residents' file in relation to this. All residents had their own bank accounts and were supported to manage

their finances by the provider with oversight from internal auditing systems and the a court appointed decision maker in the case of one resident.

All staff had taken part in human rights training. Staff were committed to ensuring that residents were provided with the opportunity to partake in ordinary lived experiences in their local community. For example, staff told the inspector that residents had recently dressed up for Halloween and gone trick or treating to staff that were off duty. One staff member spoke about positive risk taking and told the inspector that staff were "willing to give everything a try" when discussion the activities that residents were supported to take part in and try out.

Building works were planned that would provide for a female resident to have a dedicated bathroom space and further ensure that each resident's privacy and dignity was being respected in relation to their living arrangements.

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 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ard Na Gaoithe OSV-0005335

Inspection ID: MON-0038106

Date of inspection: 15/11/2024

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 Person in Charge and the team lead will ensure to conduct regular reviews of the medication management system to include the monitoring of the CDC logbook daily going forward. The medication management policy will be redistributed to all staff by the 31/01/2025 and competency assessments will be carried out by the person in charge and the Team Lead for all staff. All training is up to date and records of this are aintained. Medication management and its importance will be discussed at all team meetings on a monthly basis and in individual supervisions every 6 to 8 weeks.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Person in Charge and the Team lead have constant communication with the property department and works for premises improvements are scheduled to be carried out in the service. Regular updates will be provided to the Inspecting Officer by the Person in Charge. Works were scheduled to start in early January but due to a delay with the building contractor these works will hopefully commence in February and will be completed by 30/04/2025. All required painting and interior and exterior works will be completed with the building works	

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(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/04/2025
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	31/01/2025