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:	The Hollies
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Announced
Date of inspection:	24 October 2023
Centre ID:	OSV-0007984
Fieldwork ID:	MON-0032645

About the designated centre

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

In this centre a full-time residential service is provided to two residents over the age of 18 years. The house is a dormer type premises located a short distance from the busy local town. The house offers each resident their own bedroom and sitting room, residents share the kitchen and dining area and, other services such as the utility. There is a pleasant and well-maintained garden that residents use and enjoy. The support provided is responsive to the individual needs of each resident and ranges from staff support and assistance at all times, to periods of independence based on the assessment of any risk. The staffing arrangements reflect this and, ordinarily there is one staff on duty and, the night-time arrangement is a staff on sleepover duty. Additional staff are on duty some weekends to support the individuality of the service. The model of care is social and, the staff team is comprised of social care and support staff. Management of the service is delegated to the person in charge supported by a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 24 October 2023	10:15hrs to 15:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken to monitor the provider’s level of compliance with the regulations and standards. There were good local management systems in place that ensured both residents were supported to enjoy good health and a good quality of life closely connected to their families and the local community. However, there were failings in the wider governance structures and the provider could not demonstrate to the Chief Inspector that it had on file a current, valid and satisfactory Garda vetting disclosure for all staff members employed in this service. Therefore while there was much good practice in the centre, the provider was judged to be not-compliant with regard to safeguarding residents, governance and management and, staffing regulations.

This inspection was announced and both residents were at home waiting for the inspector to arrive. Both residents gave the inspector a great welcome to their home and invited the inspector to sit with them at the kitchen table. The assessed needs of the residents included communication differences but there was good discussion of life in the centre and life in general. At times this discussion was supported by the staff member and managers present.

One resident was very eager to discuss a trip they had enjoyed with the support of a staff member to the set of their favourite television soap. The resident enjoyed watching television and had a wish-list of sets and programmes that they wanted to visit. The resident said that they would love to be in the audience of the Late-Late show. The resident participated each year in the local St. Patrick's Day parade and shared with the inspector photographs and trophies they had won for their representation of St. Patrick. The resident described how they even grew a beard for this but never had the inclination to keep the beard once the parade was over.

There was discussion of home and family including those family members who had passed away. Both residents had regular access to home and family. One resident’s pattern of visits to family had changed. Staff said that this was the resident's own choice. It was evident from what the resident communicated that the current arrangements were in line with their expressed choices and preferences. Overall, the inspector found that residents could and did express what it was they wanted to do and did not want to do and these decisions were respected. For example, one resident was supported to spend time in the house without staff support and showed the inspector the alarm they had to contact staff if needed. A staff member described the expressions and language used by the other resident to communicate their choices and preferences. Records seen confirmed that residents were spoken with and consulted about the general operation of the service and their daily routines such as their preferred meals and activities.

The person in charge had sought feedback from residents and their representatives to inform the annual service review and this inspection. Representatives had rated the service as excellent. Residents said that they felt safe, loved their home and

hoped that they could live in it forever.

One resident offered to give the inspector a tour of the house and was evidently very proud of their home and the efforts made by staff to ensure the house looked well. For example, there were flower arrangements and Halloween decorations on display in the house and very pleasant plant containers outside. The house had been refurbished and redecorated. The resident confirmed that they had picked the colours they wanted in their areas of the house and had also helped with some small maintenance jobs.

The inspector saw that residents were comfortable in each others presence and did enjoy doing things together such as having lunch out at the weekends. However, they also had different needs and abilities. This was reflected in the arrangements put in place by the provider. For example, each resident had their own living room where they could relax and enjoy their different interests and activities. The person in charge maintained a risk assessment for possible incompatibility. Mitigations included these separate living areas, the fact that one resident attended a local wood-working enterprise Monday to Friday and, additional staffing was provided on alternate weekends.

Staff from this enterprise came to collect the resident who was delighted to show the inspector the new transport that been secured for the service. The resident happily sat into the front seat of the vehicle. The second resident had a shopping trip planned with staff and left the house shortly afterwards.

The inspector noted a very easy rapport and genuine warmth between the residents, the staff member on duty, the person in charge and the regional manager. For example, one resident loved their soft toys and dolls and this was facilitated and discussed in a respectful and kind manner. When the resident indicated they had a headache this was their way of telling the inspector that they had had enough conversation and wanted to get on with their day. When the inspector said they would go to the office to talk to the regional manager instead the resident laughed heartily and jokingly took the mangers hand.

In summary, this was a service that was focused on and responsive to the individuality of each resident. Residents enjoyed living in the centre and had a good quality of life. However, as stated above in the opening paragraph there were failings in the providers Garda vetting procedures and this impacted on the provider’s level of compliance with the regulations.

The next two sections of this report will discuss the governance and management arrangements in place and how these either ensured or did not ensure the quality and safety of the service provided to residents.

Capacity and capability

There were good local management systems that monitored the appropriateness, quality and safety of the service provided to the residents. The centre presented as adequately resourced. There were effective quality assurance systems for monitoring the internal operation of the service. However, failings in the wider governance structure created a risk to the service as the provider could not adequately demonstrate that it had arrangements in place that ensured Garda vetting was sought, received and actioned for each staff member employed.

There had been recent changes to the local management structure but based on these inspection findings these changes were managed in a way that ensured continuity of governance and management. The person in charge reported directly to the regional manager who had established experience in the management and oversight of this service. They met and spoke as needed and the regional manager convened regular meetings with the persons in charge from the region where information and learning was shared. For example, in relation to the recently formed restrictive practices oversight committee.

The person in charge had an office nearby but maintained a regular presence in the house. The person in charge was supported by a social care worker and ensured they had the protected time that they needed to complete their assigned duties and responsibilities. The person in charge was however actively involved in the planning, management and oversight of the service. For example, the person in charge maintained the staff duty rota, convened regular staff meetings, supported and supervised the staff team and, maintained good and consistent oversight of incidents that occurred and the management of risk. This was evident from records seen and discussions with the person in charge.

Quality assurance systems included this oversight of incidents and risks, oversight of practice such as medicines management and, regular consultation with residents and the staff team. In addition, the 2022 annual service review and the six-monthly reviews of the quality and safety of the service as required by the regulations were also completed. These reviews were focused on the internal operation of the centre and based on the records seen there were no concerning findings and quality improvement plans were progressed.

There was some turnover of staff and the recruitment of staff was described as challenging. The staff duty rota however did demonstrate good consistency. The importance of consistent staffing to the overall wellbeing of residents was recognised and reflected in other records seen such as risk assessments. Good oversight was maintained of staff attendance at mandatory, required and desired training.

Regulation 14: Persons in charge

The person in charge was recently appointed to the role. The person in charge had the required qualifications, skills and experience. The person in charge could clearly describe, and demonstrate to the inspector, how they planned, managed and

monitored the service provided to residents.

Judgment: Compliant

Regulation 15: Staffing

The recruitment, selection and Garda vetting of new and existing staff members was a centralised function and the responsibilities for same were set out in the providers policy on the recruitment and selection of staff. The inspector requested to review a purposeful sample of staff files to establish the providers compliance with regulatory requirements. Of the three staff files reviewed only one staff file had evidence of a current valid Garda Vetting disclosure. Disclosures had previously been sought and evidenced but had expired on the remaining two files. The disclosure available for review in one file was dated 2017. The inspector was advised that the provider required re-vetting of staff members every three years. In addition, while proof of identify was on file for all three staff members the photograph on file for two staff members was not recent as stipulated for in Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

Good oversight was maintained of staff attendance at mandatory, required and desired training. For example, records in the centre indicated that all staff working in the centre had completed training in safeguarding, responding to behaviour that challenged and, fire safety. Staff training in infection prevention and control was all up-to-date. One staff member was awaiting refresher training in medicines management. The person in charge had a risk assessment and appropriate controls in place for this while training was awaited. There was a programme of induction in place for new staff and the person in charge described responsive arrangements for the support and supervision of staff.

Judgment: Compliant

Regulation 22: Insurance

There was documentary evidence that the provider had effected contracts of insurance such as against injury to residents. The contract for the provision of a service provided to each resident advised residents and their representatives of the

insurance that was in place.

Judgment: Compliant

Regulation 23: Governance and management

The local management team monitored and assured the quality and safety of the service provided to residents and their roles and responsibilities were clear. However, the providers centralised procedures for the selection, recruitment and vetting of staff did not support the person in charge to exercise all of their regulatory responsibilities specifically in relation to ensuring that the information and documents specified in Schedule 2 of the regulations were obtained in respect of all staff members employed. There was an evident gap in the wider governance structure with regard to roles, responsibilities and accountability. There was evidence available to the Chief Inspector prior to this inspection in this regard and the provider had confirmed its decision to complete a full review of all staff files. However, what was evident from the findings of inspections was the failing of the wider organisational and governance structures to identify and address this failing. This impacted on the level of compliance achieved in this service and created possible risk to the safety of the service.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider maintained a statement of purpose and function and kept it updated to reflect any changes that occurred. For example, changes to the governance structure.

Judgment: Compliant

Regulation 30: Volunteers

The regional manager confirmed that there were no volunteers working in the service. The provider did have policies and procedures for the selection and supervision of volunteers.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector was advised that there was no recent or active complaint. The complaint procedure was prominently displayed in the main hall of the house. The person in charge said that one resident would tell her, the regional manager or other staff members if they were not happy about any aspect of their service. The other resident would communicate their unhappiness through their general demeanour and the staff team would recognise this. The feedback provided by representatives about the service was positive.

Judgment: Compliant

Quality and safety

Residents reported that they liked where they were living and had a good quality of life closely connected to home, family, peers and the wider community. The provider had arrangements in place that reflected the assessed needs of each resident including their different needs, abilities and choices. However, failings in the wider governance structure with regard to the vetting and re-vetting of staff resulted in an absence of safeguarding assurance.

The assessment or resident needs, abilities, choices and wishes had been transferred to the personal outcomes measures (POMS) format. The plan set out the care and support to be provided to each resident and how their personal goals and objectives could be progressed. For example, the desire one resident had to visit different television sets and programmes as discussed in the opening section of this report.

The personal plan included an assessment of resident health and wellbeing and the plan of care so that residents enjoyed good health. Residents were given information so that they understood the impact of certain lifestyle choices but had the freedom to make their own choices and decisions. However, staff continued to monitor, support and engage.

The personal plan also included the plan for preventing and responding to behaviour that posed a risk to the resident themselves and others including the staff team and potentially their peer. The person in charge was responsive to the incidents that staff reported, spoke to the staff team but also to both residents after incidents that had occurred. There was good staff attendance at the regular staff team meetings and records indicated good discussion of each resident and the effectiveness of their personal plans.

The person in charge maintained good oversight of the associated risk assessments. These risk assessments included the possible impact of the difference in resident

needs and abilities and how this was managed and controlled. The controls in place supported the individuality of the service and promoted rather than limited quality of life for residents. For example, additional and individualised staffing was provided at times and one resident who had previously lived independently was still supported to spend sometime in the house without staff support. The resident signed off on with staff the periodic testing of their personal alarm.

The person in charge maintained good oversight of the fire safety measures in the house such as the effectiveness of the simulated evacuation drills.

All staff had completed safeguarding training. The contact details of the designated safeguarding officer were prominently displayed and residents had good access to the person in charge and the regional manager. The person in charge understood the importance of providing staff with appropriate induction and described the formal and informal monitoring of staff practice and observation of staff and resident interactions. However, as discussed previously in this report evidence of a current valid Garda vetting disclosure was not in place in two of three staff files reviewed by the inspector. Garda vetting is a core safeguarding tool for persons working with and supporting vulnerable persons.

Regulation 11: Visits

Both residents had regular access to home and family as appropriate to their individual circumstances and wishes. There were no restrictions on visits to the house. Each resident had their own living room and so had ample space to meet visitors in private if they wished.

Judgment: Compliant

Regulation 13: General welfare and development

The support provided was individualised to the needs, abilities and wishes of each resident. For example, staffing levels were increased on alternate weekends so one resident could choose and engage in their preferred trips and events. The resident had a short period of paid employment each week and also attended with other peers a local enterprise operated by the provider Monday to Friday. The resident evidently enjoyed this and it was a meaningful and fulfilling activity for the resident. The other resident required more support from staff to successfully participate in activities such as swimming, bowling and trips to the cinema and was supported to link with peers with similar abilities. Both residents were visible in their local community and choose local events that they wished to attend such as the local market, concerts and fundraising events. Residents also liked to relax at home watching television or completing table-top activities that they enjoyed.

Judgment: Compliant

Regulation 17: Premises

Residents were provided with a comfortable and well maintained home. The design and layout of the house was suited to their needs and provided residents with opportunities to spend time together but also to have space and time alone as each resident had their own sitting room. These rooms and their individual bedrooms reflected their personal choices and interests. The house was located within walking distance of the town but transport was available. Residents has access to a pleasant garden and one resident was supported to contribute to it's maintenance as this was something that they liked to do.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were consulted with in relation to the meals provided. Residents participated in the shopping for groceries and in preparing meals as appropriate. Staff maintained a record of the meals and snacks provided and this indicated a good variety of nutritious choices. Advice such as from the dietitian was sought and staff regularly monitored resident body weight so as to monitor the effectiveness of nutritional plans.

Judgment: Compliant

Regulation 20: Information for residents

The provider maintained a guide for residents that provided each resident with information such as how to make a complaint, the visiting arrangements and, how residents were involved in the running of the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The person in charge maintained a register of the risks arising in the centre and the

controls in place to mange those risks. The risks included specified risks such as the risk for the unexpected absence of a resident and for aggression and violence. The person in charge maintained good and consistent oversight of these risks and their control and updated risk assessments as needed for example, following an accident or incident. Incidents and the learning from them were discussed with the staff team.

Judgment: Compliant

Regulation 28: Fire precautions

The house was fitted with the required fire safety measures such as emergency lighting, a fire detection and alarm system and fire-fighting equipment. There was documentary evidence in place that these were inspected and tested at the required intervals. Fire doors with self-closing devices provided for the containment of fire. What to do in the event of fire and details of the escape routes were prominently displayed. Staff and residents participated in regular simulated evacuation drills that replicated different scenarios. There were no reported obstacles to evacuation and good evacuation times were reported.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The assessment of needs and the personal plan had moved to the POM's format. While perhaps still adjusting to the new format the personal plan reviewed was very individualised to the resident, their needs, abilities and known preferences. Residents and their representatives as appropriate were consulted with and had input into their plan. The plan was available in an accessible format. The plan set out the resident's personal goals and objectives and how these were to be progressed.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident health and well-being and ensured that residents had access to the clinicians and services that they needed such as their general practitioner (GP), psychiatry, pharmacist, chiropody and dentist. Care plans in place reflected any recommendations made. Prescribed medicines were reviewed by the

relevant prescriber and, where appropriate, residents had good input into their support and care. For example, one resident managed their own medicines while staff monitored the ongoing appropriateness of this arrangement. Residents were supported to avail of protective vaccinations.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were times when one resident could be challenged to cope with certain events or activities or could use behaviour to communicate how they were feeling. Staff had access to a positive behaviour support plan. The person in charge confirmed that the plan was overseen by a member of the multi-disciplinary team (MDT). The person in charge monitored any incidents that occurred, their management and the impact on staff members and the resident's peer. The emphasis was on identifying triggers and taking corrective to prevent a reoccurrence. The person in charge had held a recent staff meeting specifically to discuss the positive behaviour support plan and, an MDT review was planned.

Judgment: Compliant

Regulation 8: Protection

The providers policy on safeguarding residents from the risk of abuse referenced a number of other associated policies that supported its safeguarding ethos and arrangements; one such policy was the policy on the recruitment and selection of staff. That policy underlined the importance of the vetting process in ensuring employment did not pose a risk to residents and others. Up-to-date Garda vetting or re-vetting also supports safeguarding and the inspector was advised that the provider re-vetted existing staff every three years. However, the provider could not provide adequate evidence to demonstrate that this re-vetting had occurred, had been received and assessed so as to identify any information that may pose a risk to resident safety.

Judgment: Not compliant

Regulation 9: Residents' rights

This was a very individualised service where the different needs, abilities and choices of residents were respected and reflected in the arrangements put in place.

For example, the design and layout of the house and the opportunities that each resident had to have different routines or to do things together if they were happy to do so. Residents were consulted with and had reasonable input into the support that they received and the general operation of the house. For example, one resident understood that staff sought to help them to make better lifestyle decisions but ultimately he could make his own decisions. Though they had a different level of understanding both residents were supported to access the internal advocacy support network. Both residents participated and contributed in their own way to the regular house meetings with staff. At these meetings staff and residents discussed matters such as this inspection, staying safe, advocacy and more routine matters such as the maintenance of the house.

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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Hollies OSV-0007984

Inspection ID: MON-0032645

Date of inspection: 24/10/2023

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• The HR Department have completed an audit of HR files pertaining to our entire workforce, specifically with regard to Garda Vetting.
• The audit found 171 staff files did not have an up to date Garda Vetting certificate on file.
• The audit confirmed there was no staff member employed without a satisfactory Garda Vetting Certificate.
• All 171 staff have been invited to participate in the Garda Vetting process. The HR Department is working with staff to ensure they have participated in the Garda vetting process by December 15th 2023. Given that the Garda Vetting process is taking approximately 4 to 6 weeks, it is estimated that the 171 staff will have up to date Garda Vetting on file by end of January 2024.
• The PICs of the relevant services will be notified by email when the Garda vetting has been received.
• As per current practice, the HR Department will review the Garda Vetting certificate received and assess, whether a risk assessment is required. Where required, this is completed by the Manager of the service and returned to HR.
• With regard to proof of identity of staff members and the requirement for all documentation as listed on Schedule 2 to be on the HR file, a further audit of all HR files is ongoing. The HR Department will have all required documentation as outlined in Schedule 2 on HR files by end of March 2024. This includes proof of identify of staff members by way of up to date passport or drivers license.
• Going forward, once a new employee commences in an area, the Recruitment Officer, will send an email to the PIC, confirming that all documentation outlined on Schedule 2 is on file. This will provide assurance to the PIC, who can request to see any of the documentation at any time.
• To guarantee a robust system of Schedule 2 compliance going forward, the provider will ensure the completion of an audit annually of HR files. The documentation outlined in Schedule 2 will form the basis of the Audit. This audit process will commence from April 2024, a quarterly basis, ensuring that 20% of files are audited within a 12 month timeframe.

• The Audit findings will be made available to the HR Manager & Clare Services Manager. A timebound action plan addressing any non-compliances or recommendations arising from the audit will be implemented by the HR Department. Annually the HR manager will present a report on compliance levels to the Clare Services Manager and Clare Management Team.
• At a National level within the organization, alterations are being made to the internal HR system, known as PIMMS, whereby the personnel in the HR Department will confirm:
o Disclosure viewed by HR, (tick box)
HR satisfied and saved on file, (tick box)

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The HR Department have completed an audit of HR files pertaining to our entire workforce, specifically with regard to Garda Vetting.
• The audit found 171 staff files did not have an up to date Garda Vetting certificate on file.
• The audit confirmed there was no staff member employed without a satisfactory Garda Vetting Certificate.
• All 171 staff have been invited to participate in the Garda Vetting process. The HR Department is working with staff to ensure they have participated in the Garda vetting process by December 15th 2023. Given that the Garda Vetting process is taking approximately 4 to 6 weeks, it is estimated that the 171 staff will have up to date Garda Vetting on file by end of January 2024.
• The PICs of the relevant services will be notified by email when the Garda vetting has been received.
• As per current practice, the HR Department will review the Garda Vetting certificate received and assess, whether a risk assessment is required. Where required, this is completed by the Manager of the service and returned to HR.
• With regard to proof of identity of staff members and the requirement for all documentation as listed on Schedule 2 to be on the HR file, a further audit of all HR files is ongoing. The HR Department will have all required documentation as outlined in Schedule 2 on HR files by end of March 2024. This includes proof of identify of staff members by way of up to date passport or drivers license.
• Going forward, once a new employee commences in an area, the Recruitment Officer, will send an email to the PIC, confirming that all documentation outlined on Schedule 2 is on file. This will provide assurance to the PIC, who can request to see any of the documentation at any time.
• To guarantee a robust system of Schedule 2 compliance going forward, the provider will ensure the completion of an audit annually of HR files. The documentation outlined in Schedule 2 will form the basis of the Audit. This audit process will commence from April 2024, a quarterly basis, ensuring that 20% of files are audited within a 12 month

timeframe.
• The Audit findings will be made available to the HR Manager & Clare Services Manager. A timebound action plan addressing any non-compliances or recommendations arising from the audit will be implemented by the HR Department. Annually the HR manager will present a report on compliance levels to the Clare Services Manager and Clare Management Team.
• At a National level within the organization, alterations are being made to the internal HR system, known as PIMMS, whereby the personnel in the HR Department will confirm:
o Disclosure viewed by HR, (tick box)
o HR satisfied and saved on file, (tick box)

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The HR Department have completed an audit of HR files pertaining to our entire workforce, specifically with regard to Garda Vetting.
• The audit found 171 staff files did not have an up to date Garda Vetting certificate on file.
• The audit confirmed there was no staff member employed without a satisfactory Garda Vetting Certificate.
• All 171 staff have been invited to participate in the Garda Vetting process. The HR Department is working with staff to ensure they have participated in the Garda vetting process by December 15th 2023. Given that the Garda Vetting process is taking approximately 4 to 6 weeks, it is estimated that the 171 staff will have up to date Garda Vetting on file by end of January 2024.
• The PICs of the relevant services will be notified by email when the Garda vetting has been received.
• As per current practice, the HR Department will review the Garda Vetting certificate received and assess, whether a risk assessment is required. Where required, this is completed by the Manager of the service and returned to HR.
• Going forward, once a new employee commences in an area, the Recruitment Officer, will send an email to the PIC, confirming that all documentation outlined on Schedule 2 is on file. This will provide assurance to the PIC, who can request to see any of the documentation at any time.

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 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	29/03/2024
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	29/03/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/01/2024