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:	Aras Aoibhinn Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	25 September 2023
Centre ID:	OSV-0001751
Fieldwork ID:	MON-0040740

About the designated centre

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

Aras Aoibhinn Residential Services is a designated centre operated by Western Care Association. The centre can provide residential care for up to four male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of one bungalow house located on the outskirts of a town in Co. Mayo, where residents have their own bedroom, some en-suite facilities, bathrooms, staff sleepover room and office, and shared access to a kitchen and dining area, sitting room and utility. A rear garden area is available to resident, to include, an sensory garden, where residents can sit and relax in, as they wish. Staff are on duty both day and night to support the residents who live in this centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 25 September 2023	09:15hrs to 13:30hrs	Anne Marie Byrne	Lead

What residents told us and what inspectors observed

This centre is run by Western Care Association in Co. Mayo. Due to concerns about the governance and oversight of Western Care Association centres and its impact on the well-being and safety of residents, the Chief Inspector undertook a targeted safeguarding inspection programme which took place over two weeks in March 2023 and focused on regulation seven (Positive behaviour support), regulation eight (Protection), regulation 23 (Governance and management) and regulation 26 (risk management procedures). The overview report of this review has been published on the HIQA website. In response to the findings of this review, Western Care Association submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, but also to assess whether the actions of Western Care Association have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Mayo. At the time of this inspection, the provider had completed a number of these actions, which had a positive impact on the quality and safety of care in this particular centre, with this inspection demonstrating good practices in relation to governance and management, positive behavioural support, safeguarding and risk management. In line with the timeframes set out by the provider within their compliance plan, at the time of this inspection, they were still in the process towards completing all remaining actions that they had committed to doing.

This was an unannounced inspection and upon the inspector's arrival to this centre, they were greeted by members of staff and by the person in charge, with the three residents who lived in this centre getting ready for the day. One resident was having a cup of tea at the kitchen table and was about to head out to their day service, while another resident was sitting in the sitting room and was observed to move about between the sitting room and kitchen, as they wished. The third resident was being supported by staff with their personal care needs, before they also headed out for the day. Two of these residents were being facilitated to have their day service delivered to them in the comfort of their own home, which the person in charge reported to be working very well for these particular residents.

These residents had lived in this centre for a number of years and got on well together. They predominately required care and support with regards to their personal care, falls management, social care and positive behavioural support. The inspector had the opportunity to meet with two of these residents, however; due to their assessed communication needs, they didn't engaged directly with her about the care and support that they received. Instead, the person in charge spoke at length with the inspector over the course of this inspection, about the specific assessed needs that these residents had, and of the arrangements in place to provide them with the supports they required.

The centre comprised of one bungalow house, located on the outskirts of a town in Co. Mayo, close to a range of services and amenities. Each resident had their own bedroom, which was decorated in accordance with their wishes. One resident had recently painted their bedroom and had many photographs of family members and other items of interest to them proudly displayed. The person in charge told the inspector that there were also plans in place to fit another resident's bedroom with a more accessible wardrobe, in accordance with their assessed needs. At the time of this inspection, the provider was in the process of completing a number of other various up-grade works, with many rooms having being re-painted and new flooring also scheduled to be laid in the coming days. The overall layout of this centre was quite spacious, which provided residents with plenty of space to comfortably move about within all communal areas. There was also an enclosed garden accessible via the sitting room, which provided various sensory features, seating and planting for residents to sit out in, as they wished. Due to some residents having a visual impairment, specific colours were painted on handrails and external steps leading up to the front door, in order to aid these residents to safely get around the centre. Overall, this was a well-maintained house that provided residents with a comfortable and homely living space.

These three residents lived very active lifestyles, with many having varying interests. Some liked to go out to have their nails done, liked arts and crafts, enjoyed GAA matches, were interested in baking and liked being out and about, just as much as watching television and films in the comfort of their own home. Others responded well to sensory based activities, and often visited the sensory room in the local library and enjoyed going for walks with staff. Others had taken up swimming and liked going out for lunch. Due to the assessed communication needs of some of these residents, staff were conscientious in trialling new activities with residents, so as to expand on the types of activities that residents responded well to. Along with a sufficient staff always rostered on duty, suitable transport arrangements were also in place, meaning these residents could be as socially active, as they wanted, within their local community.

Due to the assessed needs of these residents, the day and night time staffing arrangement was maintained under constant review by the person in charge. Many of the staff that worked in this centre had supported these residents for quite some time, which had a positive impact for residents as it meant they were at all times cared for by staff who knew them well. Familiar relief staff were also available to this centre, as and when required, who also knew these residents and their assessed needs very well. Although the person in charge held responsibility for another designated centre, they were regularly present in this centre to meet with their staff team, held scheduled staff team meetings and also ensured that staff were maintained up-to-date on any changes occurring within the organisation.

Although at the time of inspection, the provider was still working towards completing actions from the compliance plan, this was a positive inspection, which identified many areas of good practice, resulting in positive outcomes for residents. The specific findings will now be discussed in the next two sections of this report.

Capacity and capability

This was found to be a well-run and managed centre, that provided residents with the care and support that they required. Good practices were observed in relation to areas, such as, residents' assessed needs, staffing, governance and management, safeguarding, behavioural support and health care, with just some minor improvements identified to aspects of risk and medication management.

The person in charge held a full-time role and was regularly present at the centre to meet with their staff team and with the residents. They knew the residents well and their regular presence at the centre, allowed them to have effective oversight of the care that these residents received. They held regular staff team meetings to discuss resident specific care with staff, and also maintained regular contact with their line manager to review operational matters. In addition to this, they attended various other scheduled management meetings, and where any new risk or need for additional resources was identified, they had an escalation pathway available to them, to bring these matters to the attention of senior management.

The regular review of residents' assessed needs informed the staffing arrangement for this centre, which supported the provider in ensuring a suitable number and skill-mix of staff were at all times on duty to support these residents. Staff mainly supported residents with their personal care, positive behavioural support needs and to be able to get out and about each day. At the time of this inspection, in accordance with the provider's compliance plan response to the overview report, they were in the process of implementing a new on-call management system. Until this system was in place, this centre was still operating off the existing on-call management arrangement, which the person in charge told the inspector, had been effective in providing any managerial support that may be needed by staff working in this centre, during out of hours. Staff training was provided to all staff, with refresher training scheduled, as and when required. In addition to this, each staff member was provided with regular supervision from their line manager.

The oversight of the quality and safety of care in this centre was routinely monitored through the completion of six monthly provider-led visits, along with a range of other internal audits that were being completed on a scheduled basis. Where improvements were identified, time bound action plans were put in place to address these. In addition to this, the person in charge had developed a quality improvement plan specific to this centre, which outlined a number of other additional improvements that they were working towards completing. Overall, the provider had ensured sufficient resources were available in this centre, particularly in terms of, staffing, equipment and transport. Where other resources may be required from time to time, the person in charge informed the inspector that when escalated, the provider was very responsive to ensuring such resources were made available in a timely manner.

It was evident from the findings of this inspection, that the actions from the compliance plan already completed by the provider, in relation to improving

governance and management arrangements for the organisation, had made a positive impact within this particular centre. However, it is important to note, that at the time of this inspection, not all actions were yet due to be completed, with the remaining either having being commenced or in progress.

Regulation 14: Persons in charge

The person in charge held a full-time position and was regularly present in this centre to meet with residents and with their staff team. They knew the assessed needs of the residents very well, and were familiar with the operational needs of the service delivered to them. They were responsible for another designated centre operated by this provider and current governance and management arrangements, ensured they had the capacity to ensure this centre was effectively managed.

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 to support the residents who lived in this centre. Where additional staffing resources were required from time to time, the provider had adequate arrangements in place to provide this. Good continuity of care was provided, with many of the staff working in this centre, having supported these residents for quite some time.

Judgment: Compliant

Regulation 16: Training and staff development

Effective training arrangements were in place, ensuring all staff had received the training that they required, appropriate to their role. In addition to this, where refresher training was required, this was scheduled accordingly by the person in charge. Furthermore, all staff were subject to regular supervision from their line manager.

Judgment: Compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 12 actions aimed at improving governance arrangements. The provider aimed to have all actions completed by 31/01/2024. At the time of the inspection six actions had been implemented with the remainder either commenced or in progress. To date, of the actions completed, these had made a positive impact on the quality and safety of care in this centre, with better structures in place for the oversight of care delivered within this service.

The provider had ensured suitable persons were appointed to manage and oversee the running of this centre. The person in charge was supported in their role by their staff team and line manager, both of whom, they regularly had meetings with to review residents' specific care arrangements and to also review any relevant operational matters. Where new risk was identified or where additional resources were required by this service, the provider had ensured that the person in charge had a system to escalate this to senior management.

The provider had recently re-configured the overall management structure for the organisation, which had a positive impact on the governance and management arrangements for this centre. In addition, the provider had recently undertaken a full review of this centre's on-call arrangements, with a revised system due to commence in the weeks subsequent to this inspection.

Six monthly provider-led visits were occurring in line with the requirements of the regulations, and where improvements were identified, these were addressed as part of a time bound action plan. In addition to this, the person in charge and their staff team, regularly undertook a number of internal audits, which also informed any improvements required to the quality and safety of care in this centre.

Although the actions completed by the provider in relation to improving governance and management arrangements had positive outcomes for the oversight of care within this centre, at the time of this inspection, the provider was still in the process of ensuring all actions set out within this plan would be completed in line with their scheduled timeframes.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Where incidents occurred, they were reported, reviewed and responded to in a timely manner. The person in charge also ensured that all incidents were notified to the Chief Inspector of Social Services, as and when required by the regulations.

Judgment: Compliant

Quality and safety

Through many effective systems in this centre, the provider had ensured that residents' needs were routinely assessed for, that identified risk was responded to, and that residents had multiple opportunities to engage in activities that were meaningful, and of interest to them.

In their interactions with the inspector over the course of this inspection, the person in charge clearly outlined the assessed needs of each resident and of how they were being supported by staff on a daily basis. Although residents had minimal health care needs, they did have access to a wide variety of allied health care professionals, as and when required. Where any changes to residents' current health status was identified, referrals were promptly made to have this aspect of residents' care reviewed. Some required on-going positive behaviour support, and through the effective implementation of behaviour support interventions, this had resulted in very few behavioural related incidents occurring in this centre. The centre was supported by a behaviour support specialist, who reviewed residents' behaviour support interventions, as and when required. Residents' assessments were maintained up-to-date and the outcome of these informed personal plans, which guided staff on the specific care and support that residents required. This process was continually monitored by the person in charge, which had a positive impact on ensuring accurate guidance was at all time available to staff supporting these residents.

In response to previous medication errors which had occurred in this centre, daily medication audits were completed to ensure residents received the medicines each day, that they were prescribed. The person in charge told the inspector that a member of staff was allocated half an hour each day to complete this task and that to date, it was working very well in eliminating previous incidents from re-occurring. Although clear records were maintained for the prescribing and administration of medicines, some improvement was required to aspects of as-required medicines. For example, in accordance with the provider's medication management policy, a protocol was developed for each prescribed as-required medicine. However, upon review of a sample of these protocols, the inspector observed that these would benefit from additional review, so as to provide better clarity to staff on the indications for use, to warrant administration.

The management of risk was overseen by the person in charge, who ensured prompt response to any new risk identified. For example, following a change in the falls management of a resident while out and about in the community, additional review was sought from the relevant allied health care professionals, to identify if any further measures were required to be implemented, so as to further ensure this resident's safety. However, some improvement was required to the risk assessment supporting the on-going monitoring of specific organisational risk that was being carried out by the person in charge, particularly in relation to risks pertaining to the premises, staffing arrangements, fire safety and service provision.

Clear fire safety precautions were in place in this centre, with multiple fire exits available, detection and containment systems, regular fire safety checks were completed and all staff had received up-to-date fire safety training. Fire drills were conducted on a scheduled basis and the outcome of the most recent, highlighted some potential issues that may arise, should a night-time evacuation be required. At the time of this inspection, the provider had a plan in place to address this and was in the process of conducting a further fire drill the week of this inspection.

Although the provider was still in the process of completing the improvements as outlined within their overall compliance plan, this did not have any direct negative impact on the quality and safety of care in this centre. Residents were being supported by the number of staff that they were assessed as requiring, were receiving a good quality of care and experiencing a good quality of life, based on their preferences, capacities and assessed needs. It is also important to note, that at the time of this inspection, there were no safeguarding concerns in this centre.

Regulation 10: Communication

Where residents had assessed communication needs, the provider had ensured that these residents received the support that they required so as to communicate their wishes. Due to the continuity of staffing arrangements in this centre, this had a positive impact for these residents and it meant they were always supported by staff who knew how to interpret their preferred communication style.

Judgment: Compliant

Regulation 11: Visits

Residents were encouraged and supported to welcome visitors into their home, and there was adequate space provided within the centre for residents to comfortably meet with their visitors.

Judgment: Compliant

Regulation 13: General welfare and development

The provider had ensured residents had regular opportunities to get out and about in their local community to enjoy activities of interest to them. Due consideration was given to the scheduling of activities that were meaningful to residents, in accordance with their capacities and interests. As some of these residents had communication needs, sensory based activities were planned for these residents,

which these residents responded well to.

Judgment: Compliant

Regulation 17: Premises

The centre comprised of a large bungalow house, located closed to a variety of amenities. The centre was spacious, clean and provided residents with a homely living environment. Enclosed garden spaces were available to residents, which included, a sensory garden with planting and seating for residents to enjoy as they wished. Prior to this inspection, re-decoration works had been completed and new flooring was in the process of being laid. Where any maintenance works were required, the person in charge had a system in place to report this to be addressed.

Judgment: Compliant

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete three actions aimed at improving risk management arrangements. These actions related to ongoing quarterly reviews of incidents by the incident monitoring and oversight committee, incident management training and a review of the risk management policy and procedure, due for completion by the end of October 2023. One of these actions was completed, with the remainder either commenced or in progress. To date, of the action that was completed, this had made a positive impact on the risk management systems in this centre, ensuring a more timely recognition and response to risk, to ensure residents' safety was maintained at all times.

Where risk occurred in this centre, it was quickly identified and responded to, which had positive outcomes for residents. For example, following the identification of a potential risk to the falls management of a resident when they were out and about in the community, the person in charge had sought a review by the relevant allied health care professionals, to ensure this resident's safety at all times. Incidents which had occurred were reviewed and trended on a regular basis to inform risk management activities within this centre. Furthermore, risk was routinely discussed as part of staff meetings and where any new measures were being implemented in response to specific risk, the person in charge ensured that this was communicated to all staff in a timely manner.

However, there was some improvement required to aspects of risk assessment. For instance, although the person in charge maintained regular monitoring of specific risks relating to this centre in respect of fire safety, premises, staffing, potential risks

to service provision and medication management, clear risk assessments demonstrating this were not always in place to support them in their on-going work in doing so.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had fire safety precautions in place, including, fire detection and containment arrangements, regular fire safety checks were occurring, all staff had up-to-date training in fire safety and multiple clear fire exits were available. Regular fire drills were also occurring and the recent outcome of these identified some issues relating to the evacuation of some residents at night. At the time of this inspection, the provider had a plan in place to conduct a further fire drill the week of this inspection, with further plans to update residents' personal evacuation plans and fire procedure on foot of the outcome of that fire drill.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had clear procedures in place for the prescribing, administration and storage of medicines in this centre. Regular oversight of medication management practices were carried out on a daily basis, which had resulted in minimal medication errors occurring within this service. However, although protocols were in place for the administration of as-required medicines, the inspector observed that some of these would benefit from further review, to ensure better clarity was provided to staff on the indications of use for some as-required medicines.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had a system in place for the assessment and re-assessment of residents' needs. The outcome of these assessments then informed residents' personal plans, which guided staff on the specific care and support that each resident required. The updating of these assessments and personal plans were maintained under very regular review by the person in charge and where changes to residents' needs occurred, staff were promptly made aware of these changes.

Judgment: Compliant

Regulation 6: Health care

Where residents had assessed health care needs, the provider had ensured that they received the care and support that they required. This centre was supported by a variety of allied health care professionals with regards to this aspect of service, who supported in the on-going review of residents' health care needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving positive behavioural support arrangements. The provider aimed to have all actions completed by 31/01/2024. At the time of the inspection five of these actions had been implemented with the remainder either commenced or in progress. To date, of the actions completed, these had made a positive impact on the positive behavioural supports available to these residents, ensuring they received the care and support that they were assessed as requiring. However, at the time of this inspection, the provider was still in the process of ensuring all remaining actions would be completed in line with their specified timeframes.

Within this centre, where residents required positive behavioural support, the provider had ensured adequate support arrangements were in place to facilitate this, with clear guidance available to staff on how to effectively implement this. Staff were supported by a behavioural support therapist in the review of any behavioural related incidents and staff were promptly made aware of any changes made to residents' proactive or reactive strategies. These residents got on very well together and there were no reported peer-to-peer behavioural incidents occurring in this centre.

Where restrictive practices were in place, these were also maintained under regular review. There was an emphasis placed in this centre on reducing restrictive practices, where safe to do so. For example, in relation to some locked doors which were in place due to an identified risk, the person in charge had implemented a reduction in the times this restriction was in place and to date, this was working well with no negative impact to the resident that its use was intended for.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving safeguarding arrangements at the centre. At the time of this inspection, four actions had been implemented and one was in progress and not yet due to be completed. This related to the setting up of an oversight committee to ensure that there was a robust system for reviewing all safeguarding concerns in the organisation. This was due to be implemented by 31/10/2023. Of the actions that were completed, these had proved positive for this centre in strengthening overall safeguarding arrangements to ensure the safety and welfare of all residents.

At the time of this inspection, there were no safeguarding concerns in this centre. All staff had received up to date training in safeguarding and were aware that should they have any concerns relating to the safety and welfare of residents, that these were to be reported. A designated officer for safeguarding was also available to this service, in the review of any safeguarding incidents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Aras Aoibhinn Residential Service OSV-0001751

Inspection ID: MON-0040740

Date of inspection: 25/09/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has restructured the Senior Management team has to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management and oversight. The HSE Service Improvement Team has established a further workstream to include Quality, Safety and Service Improvement. The Provider awaits the final quality assurance report. The Provider has revised the unannounced visit template and unannounced visits are scheduled up to 31/12/2023. The bi-annual thematic governance and quality improvement report was presented in July 2023 with next report is due in January 2024. A learning management system has been agreed for staff training and development and the provider continues to provide monthly staff regulatory events. The quarterly properties and facilities plan has been presented at senior management for oversight with regard to its monitoring and implementation. The first management learning event took place on the 21/09/2023, and staff learning events are scheduled for the 24/10/2023 and the 07/11/2023. An organisational monthly report is submitted to the provider from the senior management team through the Chief Executive Officer.	
Regulation 26: Risk management	Substantially Compliant

procedures	

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports. Organisational policies continue to be reviewed on a regular basis and updated accordingly. The incident management policy, risk management policy and associated training modules will be completed by the 31/10/2023. A focus group is in the process of establishment to implement a systematic process for audit completion.

Although risk assessments through a risk register, the risk register needs to be specific to this designated centre only. The PIC is in discussions with the Area Manager on amending the templates to reflect that only of the service. The risk register will be revised for this service and updated to reflect this.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Person in Charge will meet with each of the named staff supporting each person living in the service to review and amend all the PRN protocols in place. This will include reviewing the need of similar PRN medications prescribed for the person and indicators of use.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Quarterly Governance and Clinical oversight has been renamed as the Critical Response Team which will meet again on the 13/12/2023. The Neurodiversity training module has been developed which will be delivered to staff up to June 2024 and refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and is reviewing the Listening and Responding Policy

The rights review committee has been re-established with regular reviews and service visits taking place to ensure independent and transparent oversight.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: The organisational safeguarding policy has been reviewed and updated in alignment to the National Safeguarding Vulnerable Person's at Risk of Abuse Policy and Procedure. A safeguarding committee has been established to ensure a robust system is in place to review safeguarding concerns. Safeguarding plans are reviewed with the HSE Adult Safeguarding and Protection Team every six weeks. A workstream has been established on safeguarding and self-guarding as part of the Service Improvement Team. The organisation will provide face to face safeguarding training to all staff by June 2024.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/10/2023
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	31/10/2023
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre	Substantially Compliant	Yellow	31/10/2023

	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.			
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	30/06/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/10/2023