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:	Blath na hOige Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	15 May 2024
Centre ID:	OSV-0001769
Fieldwork ID:	MON-0042435

About the designated centre

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

The designated centre provides a residential service to three full-time residents and there is one vacancy under review at present. Residents using this service have a primary diagnosis of intellectual disability. The centre can accommodate residents with moderate to severe care needs and additional care needs such as epilepsy and sensory deficits. Residents are supported by a primary care team which consists of both social care workers and social care assistants. Additional social care hours are deployed in the centre in response to residents' social needs. Both night duty staff and a sleep in arrangement are in place to meet the needs of residents. An integrated service is offered to one resident in the centre and all other residents access day services away from the centre. The centre comprises of one house and each resident has their own bedroom. There is also ample communal, kitchen and dining facilities as part of the design and layout of the 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
Wednesday 15 May 2024	10:30hrs to 18:00hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

This inspection was completed to monitor compliance with the regulations in line with the regulatory programme in place at present. Overall, this inspection found that the service was meeting the needs of the residents who lived there as well as supporting them to lead very active lives. The inspector found that the provider was working on the regulatory programme in place, and the local management team in this centre were found to be adhering to maintaining and sustaining a good service while responding to areas for improvement where required. This included regularly reviewing residents compatibility needs and activities. This centre was progressing in accordance with the providers compliance plan which was still underway at the time of this inspection, which will be discussed later in the report.

The 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 of Social Services undertook a targeted safeguarding inspection programme which took place over two weeks in March 2023 and focused on regulation 7 (Positive behaviour support), regulation 8 (protection), regulation 23 (governance and management0 and regulation 26 (risk management procedures0. 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, a number of actions has been implemented, with more in progress for completion. The provider had made improvements in their governance arrangements. This included an assessment of the senior and frontline management structures and the configuration of service areas with additional multi-disciplinary supports provided. These had occurred in line with timeframes of the provider's compliance plan and the management team met with said that there had been positive changes with regard to communication systems.

On arrival to the centre, the inspector met the person participating in management, as the person in charge was unavailable that day as they were on leave, the assistant manager arrived shortly after the opening meeting to assist with the inspection. The inspector provided their identification on arrival to residents and staff. The inspector was advised that two residents were engaging in scheduled activities and another resident was enjoying a leisurely home based activities as planned. This resident was supported by staff to awake and attend to their morning routine at their own leisure before commencing their individualised activity programme. At all times, staff were heard speaking and interacting in a professional and respectful manner whilst offering choice and assistance. Throughout the day the

inspector observed and noted that all staff acted in a calm manner, were knowledgeable of the residents preferences and communication styles but also of their behaviour support needs where required.

Overall, from discussions with staff, observations in the centre and a review of records, it was found that residents had a good quality of life, where they made choices about what to do and were supported to be active in their local community. in addition, the inspector noted that the management team had also responded to residents individual needs by increasing staffing to allow for additional activities outside of the centre for one resident in a couple of evenings at present. This was also in response to compatibility issues noted by the management team due to variances in residents disabilities and communication styles.

In summary, the inspector found that residents' safety and social activities were paramount to all systems and arrangements the provider had in place in this centre. Oversight systems were enhanced by the provider to ensure the quality of care provided was monitored effectively. Residents were supported and encouraged to choose how they wished to spend their time and that they were involved as much as possible in the running of their home.

Overall, this centre was found to be very focused on all of the residents care and support needs but also ensuring that each individual was provided opportunities and choice on a daily basis in this centre.The next two sections of the report present the inspection findings in relation to the governance and management of the centre, and describes about how the governance and management affects the quality and safety of service provided.

Capacity and capability

Overall, the inspector found that this centre was well monitored and the management team had effective oversight of this centre, which ensured that the residents received supported and care in line with their assessed needs and received a good quality service.

The governance and management arrangements in this centre had changed recently due to the organisation reconfiguring the regions and increasing the management structure and oversight. In addition, at the time of the inspection the person in charge was on leave and cover was in place through a newly appointed assistant manager. The inspector found that the new persons employed had settled into their roles. The service provided was person-centred while ensuring that residents were protected from harm. The inspector found that the areas for improvement related to the provider's compliance plan and ongoing actions required. These will be expanded on later in this report.

The staffing arrangements in place were reviewed as part of the inspection. A planned and actual roster was available and it showed an accurate account of staff

present at the time of the inspection. The provider ensured that the number and skill mix of staff met with the assessed needs of residents and good consistency of care and support was provided.

A review of the governance arrangements highlighted recent changes of a new management structure in place, this was clearly defined and staff were clear about their roles and responsibilities therefore the lines of authority. At the time of the inspection, the person in charge was on leave, but cover was in place with an assistant manager who had recently commenced and was familiar with the service. The inspector found that staff were knowledgeable and skilled in supporting the residents.

The annual review of the quality and safety of the service was completed and up to date, but also showed relevant actions for completion, which was linked to the provider compliance plan response. In addition, the six monthly unannounced provider-led audit was completed in the time-line required and a number of actions were identified and actioned. Staffing in place was provided by a core team which provided consistency of care and support provided. Team meetings were taking place regularly. A review of incidents occurring in the centre found that they were clearly documented and if required reported to the Chief Inspector in line with the requirements of regulation 31.

Overall, the inspector found that the governance and management arrangements had significantly improved in this centre which, resulted in a safe and effective service was provided. This led to good outcomes for residents' quality of life and for the care provided in this centre.

Regulation 15: Staffing

The provider ensured that the number and skill-mix of staff was appropriate for the needs of residents. consistency of care and support was provided.

Judgment: Compliant

Regulation 16: Training and staff development

The management team showed that an accurate training record was in place and monitored as required. Plans were in place for refreshers where required and a training needs analysis was completed.

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 and arrangements at the centre. The provider aimed to have all actions completed by 31/01/2024. At the time of the inspection eight actions had been implemented with the remainder in progress.

Completed actions included an assessment of the senior and frontline management structures and the reconfiguration of service areas, the establishment of a new incident monitoring and oversight committee and a reinstated human rights committee, and the introduction of new arrangements for unannounced provider visits. in addition, a standardised monthly report writing template was introduced to the service and regulatory information events were provided for staff.

The inspector found that the remaining four actions were commenced and were progressing. The quality, safety, and service improvement department were finalising the review of service audits. The governance and quality improvement framework was in draft form and under review. A training and development project group was established and they had selected an information system which would enhance and support the staff training arrangements in place. This included a review of the policy, procedures and guidelines which were not yet established or embedded into the organisation.

It was clear that the management team was very well informed of the ongoing actions taken by the provider to strengthen the governance and management arrangements.

Judgment: Substantially compliant

Regulation 30: Volunteers

There was a policy and procedure in place to ensure that if volunteers were utilised that management and staff were guided on on this practice in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had submitted all notifiable events to the chief Inspector and within the specified time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy and procedure in place as required by the regulations. All complaints or compliments were logged and an appropriate response noted. There was also an identified complaints person in the centre, who contact details were clearly displayed for residents and representatives if required.

Judgment: Compliant

Quality and safety

The inspector found that the service provided in Blath Na hOige Residential Service was person-centred and residents were supported to live rewarding lives as active participants in their community.

The staff team ensured that the resident's health, personal and social care needs were assessed. Care and support plans were developed, as required. Meetings occurred with the resident's family representatives where priorities and goals for the future were reviewed and agreed. Staff spoken with talked about the activities the residents enjoyed which, included attending day services, trips on the transport provided and additional hours to support residents having individual time out of the centre to sample activities of preference.

As outlined, residents that required support with positive behaviour support had specialist supports in place. Further meetings were planned in order to review and monitor the behaviour support plans in place. The policy on behaviour support was up-to-date and staff training was provided. Minimal restrictive practices were in use in this centre, with those in place reviewed regularly and when agreed removed when no longer required. Those practices used were the least restrictive and only used when necessary.

A review of a safeguarding and protection plan found that it was completed in accordance with local and national policy. It addition, plans were linked to behaviour support strategies and corresponding risk assessments were in place. The safeguarding policy was up-to-date and all staff had completed training. Intimate care plans were available for review. The team leader was clear on what to do if a concern arose and the identity of the designated officer was clearly displayed in the centre. This was an action from the provider's compliance plan.

At this centre, the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system for responding to

emergencies. Policies on risk management were available for review and safety statements were up to date. Risk assessments for service level risks were in place and each resident had a personal risk management plan.

As outlined, the premises provided was clean, comfortable and suitably decorated throughout. The provider had taken action to ensure that matters identified previously were addressed. This included the painting and decorating of the centre. This house met the requirements of the assessed needs of residents at the time of this inspection.

In summary, residents at this designated centre were provided with a good quality service where their independence and autonomy was promoted. There were good governance and management arrangements in the centre which led to improved outcomes for residents' quality of life and care provided. Ongoing progress with the actions committed to by the provider on their compliance plan would further enhance the service and the quality of the care and support provided.

Regulation 13: General welfare and development

Following the last inspection, significant improvements had occurred which enable all residents to lead and active and where required individualised and age appropriate activities in the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through the its compliance plan to complete three actions aimed at improving the risk management arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection two actions were completed and one was in progress.

Actions completed included a review of the risk management policy and the introduction of a quarterly process of incident review.

The inspector found that one action in relation to incident management training was in progress.

In this centre, the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system to responding to emergencies. Policies on risk management were available for review and safety statements were up to date.Risk assessments for service level risks were in place

and each resident had a personal risk management plan.

Judgment: Substantially 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 behaviour support arrangements at the centre. The provider aimed to have all actions completed by 30/06/2024. At the time of the inspection the provider had completed six of these actions. The seventh action had commenced and was in progress.

Completed actions included the appointment of an interim head of clinical and community support and the appointment of additional multi-disciplinary supports. Under the leaderships of the psychology team, a governance and clinical oversight group and a behaviour support oversight group was established in order to co-ordinate the response to critical incidents. A review of the role and function of the psychology team was completed and guidance on the referral pathways was developed.

The inspector found that one action was in progress. The training module in neuro-diversity was developed, a pilot was completed and that full roll out of the training module had commenced with management and some staff at the time of the inspection.

In this centre, the inspector found that residents that required support with positive behaviour support had specialist supports in place. The policy on behaviour support was up-to-date and staff training was provided.

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. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection, all actions were completed.

These included the establishment of a safeguarding oversight committee, updating of the provider's safeguarding and protection policy and the introduction of a six monthly review system for open safeguarding plans. In addition, staff had access to face to face training in safeguarding and protection and new systems were in place

to improve staff awareness of the contents and actions of open safeguarding plans.

At this centre, the inspector found that residents were supported to understand the need for self-care and protection. If safeguarding plans were used, the inspector found that the team leader had a good awareness of the plans requirements and that the actions were integrated into the behaviour support strategies and personal risk management plans.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that the residents rights were paramount in this centre, for example staffing had been increased to facilitate additional individual activities or outings for a resident. This had commenced at the time fo the inspection and this was to ensure that residents had choice in their daily activities.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Blath na hOige Residential Service OSV-0001769

Inspection ID: MON-0042435

Date of inspection: 15/05/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	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 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. Under the remit of the HSE's Service Improvement Team the Models of Service sub-group has been merged as part of the Quality, Safety and Service Improvement workstream. The Provider has revised the unannounced visit template and unannounced visits are scheduled up to 31/7/2024. The next bi-annual thematic governance and quality improvement report will be presented to the Board at the end of July. A learning management system pilot has commenced in two service areas for staff training and development and aims to implement the system to the rest of the organisation by the end of the year. The provider continues to facilitate monthly staff regulatory events. The quarterly properties and facilities plan is presented at senior management for oversight with regard to its monitoring and implementation. An organisational report is submitted to the provider from the senior management team through the Chief Executive Officer every 2 months. The provider has submitted a business case to the commissioner of services to strengthen the current on-call arrangement. An interim arrangement is being developed with Front Line Manager through the Area Teams agree an on-call system by the 30.06.2024.	
Regulation 26: Risk management procedures	Substantially Compliant
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.

The training module on the revised incident management framework policy commenced on the 15/05/ 2024. The risk management policy and associated training module are in consultation stage with various stakeholders for organisational implementation. The Risk Management Framework will be presented to the QSSI workstream for stakeholder engagement. Following consultation, a draft framework and training module will be presented to the Senior Management Team on the 17/06/2024.

The pilot project will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Governance and Clinical oversight Group has been renamed as the Critical Response Team and meets on a quarterly basis. The Neurodiversity training module commenced with refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and the Listening and Responding Policy has been reviewed and will be considered by key stakeholders prior to implementation. The Inter Clinical Team Working Policy will be completed by the 30/06/2024

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	30/06/2024
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	30/06/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in	Substantially Compliant	Yellow	30/06/2024

	place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/06/2024