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:	Lannagh View Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	28 February 2024
Centre ID:	OSV-0001771
Fieldwork ID:	MON-0040741

About the designated centre

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

This centre is a five bedded bungalow located in a quiet residential area outside a large town in Co. Mayo. It is in close proximity to shops, parks, bars, restaurants and the theatre. The centre provides a residential service to adults aged 18 or over, both male and female who have and intellectual disability with varying levels of support needs. This centre operated on a full-time basis, 7 nights for 52 weeks per year. There is a minimum of two staff members on duty at any one time, and there is a waking night and a sleep in staff on duty at night.

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 28 February 2024	10:00hrs to 17:00hrs	Alanna Ní Mhíocháin	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 7 (positive behaviour support), regulation 8 (protection), regulation 23 (Governance and management) and regulation 26 (risk management procedures). The overview report of this review has been published on the Health Information and Quality Authority (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 the inspection a number of actions had been completed and the others were in progress. The governance arrangements had been strengthened through the development of new senior management posts, the reconfiguration of service areas and the introduction of new management meetings. Staff reported that the new arrangements had resulted in improved communication between staff in the centre and senior management. Information sharing between centres had also improved.

The centre was registered to accommodate four residents. One the day of inspection, three residents were living in the centre and the fourth bedroom was used as a staff office. The person in charge was not available on the day of inspection. The inspection was facilitated by the area manager. Overall, the inspector noted that the service in the centre was of a good quality. Some improvement was required in relation to the on-call management arrangements and the development of residents' risk assessments.

The centre was a bungalow in a housing estate. It was located in a large town near shops, restaurants and other local amenities. The centre was accessed via a ramp at the front door and a second ramp to a patio door into the dining room. Each resident had their own bedroom. The centre had two bathrooms with level access showers. The centre also had a kitchen, dining room, sitting room and utility room. Outside, the garden and grounds were well maintained and accessible.

The centre was clean, tidy and homely. It was in a very good state of repair. All rooms had recently been painted. The furniture was new and comfortable. Residents' bedrooms were decorated in line with their tastes and they had adequate storage for their belongings. Some residents had televisions in their bedrooms. The home was personalised with the residents' photographs and artwork. The kitchen was well stocked with fresh food and staff were observed preparing wholesome

meals for residents.

The inspector had the opportunity to meet with all three residents at different points throughout the day. One resident said that they were happy in their home. They said that the staff were nice and that the food was good. The other two residents greeted the inspector but did not want to engage in conversation. Residents left the centre in the morning to attend day services. They returned in the afternoon where staff supported them with personal care and prepared the evening meal.

Staff were familiar with the needs of the residents and the supports required to meet those needs. Staff knew who to contact should an incident occur in the centre and were knowledgeable of safeguarding procedures. They spoke about the support they received from management. They were familiar with the documentation in the centre that outlined the residents' care needs. They spoke about the residents in a respectful manner. Staff spoke about the ways that they offered choices to residents throughout the day and how these choices were respected.

Overall, the inspector found that residents enjoyed a good quality service in this house and were supported to engage in activities of their choosing. The centre was suited to meet the needs of residents. The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affects the quality and safety of the service provided.

Capacity and capability

In this centre, the provider maintained good oversight of the service through a number of audits and through review of incidents in the centre. Staffing arrangements and training were adequate to meet the needs of residents. However, a review of the on-call management arrangements required improvement.

The management structure and lines of accountability were clearly defined. Staff knew who to contact should any issues or incidents arise. Incidents in the centre were recorded, reviewed by the person in charge, and escalated to the area manager. Trending and review of information in incident forms was completed routinely by management and at the provider's incident review group. Any actions needed to avoid a reoccurrence of the incident were identified and implemented. However, the arrangements for contacting a member of management outside of regular hours required review. On the day of inspection, there was no roster of out-of-hours management cover. There was a system whereby managers were listed by hierarchy and staff were directed to begin by contacting their immediate line manager. If that manager was unavailable, staff were directed to continue to the next level of management until they received a response. This meant that managers were effectively on-call at all time and that the director of operations had to be contactable at all times. This system was not sufficiently robust to ensure that staff could escalate any incidents or emergencies when they arose and receive a

response in a timely manner.

Staff were kept informed of relevant issues through regular team meetings. These meetings covered issues relating to the care of the residents, for example, updates on residents' behaviour support plans, and issues relating to the service as a whole, for example, fire drills. Every second month, the area manager met with persons in charge and managers of day services within the area. Meetings between area managers occurred every two weeks. In line with the provider's compliance plan, senior management also met every two weeks. Minutes from these meetings were circulated and available for staff in the centre. The area manager reported that these meetings were beneficial as they allowed shared learning between managers and centres. It also allowed for two-way communication between staff in the centre and senior management.

The provider maintained oversight of the service through a number of audits. There was a schedule that outlined when the audits should be completed. There was evidence that audits were completed routinely and that the issues identified were addressed. The provider had completed an annual report and six-monthly unannounced audits into the quality and safety of care and support in the centre.

The staffing arrangements in the centre were appropriate to meet the assessed needs of residents. Staff were employed on a regular basis and were familiar with the needs of residents. The provider had identified a number of training modules that were required by all staff and staff training in these areas was up to date.

Overall, the inspector found that the provider maintained oversight of the quality of the service. Staffing and staff training was adequate to meet the needs of residents.

Regulation 15: Staffing

The number of staff on duty was suited to the needs of residents. The team was consistent and staff were familiar with the needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified a number of training modules for staff. Staff training in these modules was up to date.

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 at the centre. 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 in progress.

Completed actions included:

- a reconfiguration of service areas.
- a review of senior management structure
- the development of a service improvement team
- scheduling of six-monthly unannounced audits of centres and allocating a manager from outside of the region to complete these audits
- the re-establishment of an incident review committee
- the development of a standardised monthly reporting template

The actions that were in progress can be summarised as follows:

- The assessment and review of frontline staff was ongoing and on-call arrangements had not been addressed in this centre
- The review of audits was ongoing. The new audits were due to be piloted on a new computer system in February 2024.
- The new training system was piloted in two areas but not yet rolled out across the organisation
- Most staff had attended regulatory information events with eighteen staff yet to attend.
- The provider had completed the final draft of the policy and procedure framework but this had not yet been circulated to staff.
- The human rights committee had been re-established but the independent chair had yet to be appointed.

In this centre, the provider had clearly defined lines of accountability. Oversight of the service was maintained through routine audits. Issues identified on audit or through incidents were addressed. Staff were kept informed of developments within the centre and the wider organisation through regular staff meetings.

Judgment: Substantially compliant

Quality and safety

The service in this centre was person-centred and of a good quality. Residents' needs were identified and supports were provided to meet those needs. Residents'

right were respected. Residents' safety was promoted. However, some improvement was required in relation to the residents' risk assessments.

The centre itself was homely and in very good structural and decorative repair. The house was clean and tidy. It was personalised with the residents' photographs and artwork. There was adequate room for residents to spend time alone or together, as they so wished. There were suitable facilities for cooking and laundry. The house was fully accessible to all residents.

Residents' health and social care needs were identified. Care plans and guidance documents were available to inform staff on how to support residents meet these needs. Residents had personal plans that outlined their goals for personal development. The residents' needs were reviewed annually with input from the resident, their family, and members of the multidisciplinary team. Residents had access to a number of healthcare professionals, as required. The residents' scheduled appointments for the year ahead were documented and residents were supported to attend these appointments. Regular health checks were completed by staff in the centre.

Where required, residents had behaviour support plans that were devised by appropriate healthcare professionals. There was evidence that staff regularly engaged with these professionals to give updates on residents' needs and to instigate reviews of current supports. Staff were aware of the contents of the plans. Where medication was required to support residents with their behaviour, there were very clear protocols in place to guide staff on when to administer this medication.

The provider had taken steps to protect residents from abuse. Where required, safeguarding plans were devised, implemented and reviewed. Residents were supported to develop knowledge and skills for self-care and protection. Staff used communication strategies that supported the residents' understanding of safeguarding measures. Residents individual risk assessments also guided staff on how to reduce risks to residents and to keep them safe. The risk assessments were regularly reviewed. However, the inspector noted that not all risks had been identified and documented for one resident. The centre also had a risk register that outlined risks to the service as a whole. These risk assessments were comprehensive and were regularly reviewed.

The rights of residents were respected in this centre. Residents were registered to vote and their polling cards for an upcoming referendum had been delivered to the centre. Residents were routinely offered choices in their daily lives. Residents were consulted and their consent was sought in relation to their care. For example, a resident's consent was sought to make a referral to advocacy services. Where restrictions were implemented as part of the residents' behaviour support plans, these were reviewed by an external rights review committee.

Overall, the inspector found that residents in this centre were supported to meet their health and social needs. Residents' rights were promoted and they had choice in their daily lives.

Regulation 10: Communication

Residents' communication needs were identified. Supports were in place to meet the residents' communication needs. Staff were aware of the strategies that should be used to support residents with their communication.

Judgment: Compliant

Regulation 17: Premises

The premises were suited to the needs of residents. The centre was in a good state of repair and nicely decorated. There was adequate private and communal space in the centre. The centre was fully accessible to the residents.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were supported to buy food that was wholesome and nutritious. Food was prepared in line with the residents' dietary needs. Residents had choices at mealtimes.

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 governance arrangements at the centre . The provider aimed to have all actions complete by 31/10/2023. At the time of the inspection, one action had been completed and two were in progress.

The action that had been completed was:

- incidents were reviewed on a quarterly basis by an incident review committee.

The actions that were in progress were:

- training in incident management had been delivered to senior managers but had not been rolled out to staff in the designated centres
- the risk management policy had not been finalised

In this centre, there was a comprehensive risk register that outlined the risks to the service as a whole. The risk assessments in this register were relevant to the centre and regularly reviewed. Residents also had individual risk assessments. These gave guidance to staff on how to keep residents safe. However, for one resident, not all identified risks had a corresponding risk assessment.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The health and social needs of residents had been assessed. Guidance for staff on how to support residents with these needs had been devised and were updated routinely. Residents had personal plans that outlined their goals for personal development. The assessment and personal plan was reviewed annually with input from the resident, their family representative, and members of the multidisciplinary team.

Judgment: Compliant

Regulation 6: Health care

The healthcare needs of residents were well managed. Residents had a named general practitioner. Residents were supported to attend appointments with relevant healthcare professionals. There was evidence of follow-up on health checks.

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 governance arrangements at the centre . The provider aimed to have all actions complete by 30/06/2024. At the time of the inspection, four action had been completed and three were in progress.

The completed actions included:

- an interim head of clinical and community support had been appointed
- additional multidisciplinary team practitioners had been employed
- a critical response team was established to review the placement of residents when required
- a behaviour oversight committee was re-established

The actions that were in progress included:

- the policy on the role of psychology and interdisciplinary team working was in draft form
- the training modules on neurodiversity were being finalised and training to managers was due to commence on 29/02/2024
- the access to appropriate multidisciplinary team supports was ongoing, for example, the standardised template for behaviour support plans had not yet been introduced.

In this centre, behaviour support plans for residents were devised by appropriate healthcare professionals.. Staff were knowledgeable of their content. The behaviour support plans were regularly reviewed. Where restrictions were required as part of the plans, these restrictions were reviewed by an external rights review committee.

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 governance arrangements at the centre . The provider aimed to have all actions complete by 31/10/2023. At the time of the inspection, three actions had been completed and two were in progress.

The completed actions included:

- a new system was in place to improve staff awareness of the safeguarding process
- active safeguarding plans were reviewed on a quarterly basis
- a safeguarding oversight committee had been established

The actions in progress included:

- the safeguarding policy was in review
- face-to-face training in safeguarding had not been rolled out to all staff

In this centre, the provider had taken steps to protect the residents. Safeguarding issues were identified, escalated and reviewed. Safeguarding plans were devised

and implemented. The residents' risk assessments and behaviour support plans gave guidance to staff on how to keep the residents safe

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights were respected in this centre. Residents were offered choices and their choices were respected. Residents were consulted on their care and their consent was sought to make onward referrals. Residents were supported to exercise their civil and political rights.

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
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	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
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lannagh View Residential Service OSV-0001771

Inspection ID: MON-0040741

Date of inspection: 28/02/2024

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 in March.

A learning management system has been agreed for staff training and development and 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.

The Provider is appraised of organisational updates related to clinical and community supports, operations, safeguarding and protection, human resources, finances, properties and facilities and quality, safety and service improvement through the submission of a report every 2 months.

The provider submitted a business case to the commissioner of services in January 2024 for funding to strengthen the current on-call arrangement.

Current on call arrangement is in place using the line management contact up to and including Senior Management Team.

An interim arrangement is being developed with Front Line Manager through the Area Teams agree a system- 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 incident management policy, risk management policy and associated training modules are in consultation stage with various stakeholders for organisational implementation. The pilot project will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review.

When the incident injury policy is released training will be provided to staff teams- pilot 29.04.2024.

Risk management policy will be released and training will be provided to staff teams 07.05.24.

The incident management policy, risk management policy and associated training modules are in consultation stage with various stakeholders for organisational implementation. The pilot project will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review 29.04.24.

Individual risk assessment updated for one resident – completed on 14/03/2024, also included in Personal Risk Management Plan.

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 meet on a quarterly basis. The Neurodiversity training module has been developed and will be delivered to staff by June 2024 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 updated BSP template and policy will be completed by the end of April

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. The organisation will provide face to face safeguarding training to all staff by June 2024.

Service Update: All staff within the service have now completed both face to face and online Safeguarding Training (as of 14.04.2024)

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	31/07/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	07/05/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Substantially Compliant	Yellow	14/04/2024

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/06/2024