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

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| Name of designated centre: | Forest View Apartments |
| Name of provider: | Western Care Association |
| Address of centre: | Mayo |
| Type of inspection: | Unannounced |
| Date of inspection: | 01 May 2024 and 16 May 2024 |
| Centre ID: | OSV-0001783 |
| Fieldwork ID: | MON-0042971 |

## About the designated centre

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

Forest View apartments is a designated centre which has been designed to provide full-time accommodation for three residents. The service can accommodate both male and female adults who may have autism, additional complex needs and behaviours of concern. The centre consists of three individualized apartments and separate staff accommodation which is adjacent to the apartments. The centre is located in a rural setting and is within walking distance of a day centre, which some residents attend. Forest View apartments have access to their own transport to enable residents to access the community. A social care model is provided in this centre, and a combination of social care workers and social care assistants support residents with their daily needs. Residents are supported by up to three staff during daytime hours and two staff provide sleepover cover each night.

**The following information outlines some additional data on this centre.**

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| 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 1 May 2024 | 10:40hrs to 16:55hrs | Alanna Ní Mhíocháin | Lead |
| Thursday 16 May 2024 | 15:45hrs to 18:15hrs | 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 wellbeing 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 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 the provider had completed a number of actions while others had been commenced and were in progress. The governance arrangements had been strengthened through the assessment of senior management structures. Service areas had been reconfigured. A number of committees had been re-established in the organisation . Staff training modules had been commenced.

In this centre, there had been numerous changes in the role of person in charge since April 2023 and this had impacted on the effectiveness of the governance and oversight of the service. As a result, information was not provided to staff in order to ensure that residents received the supports they required. Poor documentation and information sharing resulted in unclear guidance to staff on how to support residents manage their behaviour, how to manage risks to residents, and how to promote the rights of residents. It was not clear how residents should be supported to communicate their needs and wishes. Residents were not always consulted on what activities they would like to engage in. Improvement was required in relation to the oversight of the centre. Audits were not completed in line with the provider's schedule and the information gathered was not always adequate to identify areas for service improvement.

The inspection took place over two days. The first day of the inspection was unannounced. On that day, two of the residents were not in the centre as they were attending day services and the inspector had limited opportunities to speak with the third resident. Due to an incident that occurred in the centre, the first day of inspection was concluded before the residents returned home. The inspector returned to the centre on 16 May 2024 to meet the residents and to speak to staff. The inspector gave 24 hours' notice to the provider before attending the centre on the second day.

The inspection was facilitated by a person participating in the management (PPIM) of the centre. The person in charge was unavailable on the day of inspection. The role of person in charge was due to change in the coming weeks and a new staff member had been appointed into the role. This person was undergoing induction at the time of inspection.

The centre consisted of three separate apartments. The apartments were located in a very rural location a few minutes' drive from a town. The apartments were next to buildings that were used by the provider for day services. Each apartment had its own entrance. The apartments had a bedroom, a bathroom with level access shower, and a kitchen-living room. There was a central space between the three apartments that contained a staff office, two staff sleepover rooms, and the laundry facilities for the apartments. Each apartment could be accessed from this central point through doors with keypad codes. This central section of the building also had its own entrance. Outside, the residents had three separated areas with outdoor seating. The residents also had access to the grounds around the day centre buildings.

The inspector viewed each of the three apartments. Overall, the centre was clean and tidy. Each apartment was decorated in different styles and colour schemes. Some homely touches had been added to the residents' apartments. For example, artificial fireplaces had been added to the living rooms. However, the inspector noted areas of wear that required improvement. The couch in one apartment was worn and missing an arm. An armchair in another apartment was worn with cracked coverings on the arms. In one resident's bedroom, it was noted that access to drawers was restricted due to the placement of the furniture in the room.

On the first day of inspection, the inspector briefly met with one of the residents. When asked if they were happy in their home, they indicated 'yes' by tapping the inspector on the hand. One the second day of inspection, this resident indicated that they did not wish to speak to the inspector by pushing the inspector's hand away. The inspector noted that this resident spent time relaxing in their living room and walking around the centre. At one point, the resident was seen giving a member of staff a hug when they returned from a walk. The other two residents were unavailable to meet the inspector on either day of inspection.

The inspector noted that a resident's apartment was accessed by someone who did not live or work at the designated centre during the first day of the inspection. This occurred while the resident was out for a walk. This person was known to the resident, however, it was unclear if the resident had given consent for the person to be in their apartment. The inspector asked the PPIM if the resident had consented for someone to access their apartment in their absence. The PPIM reported that this did not occur frequently but it was not clear if the resident had consented to this.

In addition to the PPIM, the inspector met with the manager of the service and three members of staff. Staff spoke about the supports offered to residents in the centre. Staff were knowledgeable on the residents' likes and dislikes. They could outline the behaviours that indicated that residents were unhappy or upset. However, they were less clear on the supports that should be offered to residents at

these times. Staff gave information in relation to supporting one resident at night that was in contradiction to the information in the resident's behaviour support plan. Staff were also unclear on the ways in which residents were offered choices and consulted about activities. Some staff were knowledgeable on the steps that should be taken in the event of a safeguarding incident. However, the inspector noted a safeguarding incident that occurred in the centre that was not identified by staff. The inspector reported it to the PPIM and appropriate actions were taken to protect the resident.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

## Capacity and capability

The provider had established defined lines of accountability. Staffing numbers and skill-mix were suited to the needs of residents. However, improvement was needed in relation to staff training. The provider had identified ways to maintain oversight of the service. However, improvement was required to ensure that service improvement issues were identified and addressed.

The staffing arrangements in the centre were suited to the needs of residents. The PPIM reported that there were no vacancies in the centre at the time of inspection. The PPIM reported that staff hours were flexible in order to accommodate the needs of residents. A new staff-training record system was being piloted in the region at the time of inspection. The PPIM said that this system made it much easier and more efficient to arrange staff training. Staff training records indicated that the provider had identified a number of mandatory training modules and some modules that were specific to the care of the residents in the centre. All staff had up-to-date training in some modules. However, in other areas, improvement was required in order to ensure that staff had the necessary skills to support residents, particularly in areas that the provider had identified as high-risk to residents.

The management of the centre at a local level was undergoing change at the time of inspection. The role of person in charge was due to change in the coming weeks. The person due to take over that role had been appointed and a process of induction was underway at the time of inspection. The management structure in the centre was clearly defined. Staff knew who to contact should any issues arise.

Improvement was required in relation to the oversight of the service. The provider maintained oversight through a review of incidents that occurred in the centre and though audit. Incidents that occurred in the centre were recorded, reported and escalated. There was a process where incidents that happened in each quarter were reviewed to see if any trends were emerging. The inspector found that, in some cases, incidents relating to resident's behaviour were reported to the behaviour

support service but this did not occur in all cases.

The provider had a suite of audits that were due to be completed at different times in the centre. A review of the centre's audit folder found that they were not always completed in line with this schedule. The quality of information obtained through these audits did not always identify areas for service improvement. Where issues were identified, it was not always clear that these issues had been addressed by the provider.

## Regulation 15: Staffing

The staffing arrangements in the centre were adequate to meet the assessed needs of residents.

The inspector reviewed the rosters from 18 March 2024 to 02 June 2024. This indicated that the necessary number of staff were on-duty at all times. Additional staff were available two evenings a week to support residents engage in social activities. The PPIM reported that these hours were flexible in order to accommodate residents' social activities. Staff were consistent and familiar to the residents.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had received training in modules that the provider had identified as mandatory. However, not all staff had up-to-date training in all modules. Of note, not all staff had received training in areas that had been identified as high-risk by the provider.

A review of the training matrix indicated that all staff had completed training in some areas. For example, all staff had completed on-line training in safeguarding. However, it was noted that a significant number of staff had not received training in areas that that provider had identified as the highest risk in the centre. For example, on the centre's risk register, the risks associated with feeding, eating, drinking and swallowing had been identified as one of the highest risks in the centre. Only three out of 13 staff had completed training in the theory module for this area. Only seven staff had completed the practical competency module in this area. The PPIM identified a training date for the competency module before the end of the inspection.

Judgment: Not 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 January 2024. At the time of the inspection, seven actions had been implemented with the remainder in progress.

Completed actions included:

- a review of senior management structure
- a reconfiguration of service areas
- the development of a service improvement framework and team. This team met on 13 March 2024 and individual workstream teams met on a monthly or six-weekly basis.
- 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 Human Rights Committee had been established

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

- The assessment and review of frontline staff was ongoing. A plan was in place to commence meetings between all persons in charge in the near future.
- The review of audits was ongoing. A new template for the six-monthly unannounced visits had been devised. However, a review of audits used within centres had not been commenced.
- The new staff training system was piloted in two areas. This designated centre was included in the pilot scheme. A roll-out of the new system was scheduled for the rest of the organisation in the next quarter.
- A number of staff had attended regulatory information events and further dates had been scheduled in May and June.
- The provider had completed the final draft of the policy and procedure framework but this had not yet been circulated to staff.

In this centre, there were clear lines of accountability and staff knew who to contact with any issues that may arise. There were regular meetings between members of management where information and learning could be shared. For example, a meeting of all persons in charge and managers of day services in the region had taken place on 30 April 2024. Area managers also met every two weeks to share information across the organisation.

However, improvement was required in relation to the oversight of the service. The provider had devised a suite of audits that were due to be completed monthly in the centre. A review of the audits found that these were not completed in line with this schedule. For example, a medication audit had not been completed since November

2023. In addition, the quality of information obtained through these audits did not always identify areas for service improvement. For example, the monthly financial audits listed tasks that needed to be completed rather than identifying actions that should be taken to identify and address issues.

Further, where service improvement issues were identified, it was not clear that these had been addressed. For example, a review of one resident's finances in January 2024 found that a small sum of money was missing from their wallet. However, there was no record that this had been followed-up or investigated.

Where incidents occurred in the centre, these were recorded and reported to senior managers. A review of the incidents that occurred in each quarter was completed. This review identified if there were any trends in the incidents reported in the quarter and if any additional training or supports were required to prevent a reoccurrence.

Judgment: Substantially compliant

## Quality and safety

Significant improvement was required in relation to the provision of information to staff in relation to the supports required by residents. The absence of clear, accessible information meant that residents were not always supported in line with their care plans. Supports to ensure that residents' rights were promoted and upheld were not always in place.

The needs of residents had not been adequately assessed in this centre. As a result, it was not clear if the supports for residents had been identified and implemented. This was reflected in the residents' personal plans where assessments of need had not been updated within the previous 12 months. The information contained within the plans was not always accessible to staff, for example, documents had not been printed. Some information in the plans was conflicting so that it was unclear what supports were required by residents to meet their needs and to reduce risks. This resulted in inconsistent strategies being used by staff when supporting residents and the supports may not have been in line with their needs. This increased the risk to residents' safety.

Improvement was required in order to ensure that residents were consulted about their care and supported to actively participate in activities that were meaningful to them. The communication needs of residents had not been adequately assessed and, as a result, it was unclear how to support residents to express their needs and wishes. Staff guidance on supporting residents to manage their behaviour was not clear. Relevant behaviour support specialists had not always been consulted to inform staff practice when supporting residents. This had an impact on the residents' quality of life as they were not always supported to engage in activities of

their choosing and to express autonomy in their daily lives.

## Regulation 10: Communication

Although the provider made information available to staff in relation to the residents' communication needs, improvement was required in order to ensure that residents received supports to communicate their needs and wishes.

Residents' files contained communication profiles that outlined how residents expressed their needs and strategies to support their communication. The inspector reviewed two communication profiles and noted that the documents were not dated. In addition, the name of the person who had completed the document was not recorded. Therefore, it was unclear if the information was still relevant to the resident and if the profile had been completed by an appropriate individual familiar with the residents' communication needs.

The inspector observed two members of staff speaking with a resident. Both staff members used two different communication strategies when asking the resident questions. When asked about communication strategies, staff gave conflicting information about the methods used to support the resident indicate their needs and preferences.

Judgment: Not compliant

## Regulation 13: General welfare and development

Significant improvement was required in order to ensure that residents were supported to engage in activities that were in line with their interests.

The inspector reviewed a resident's daily notes for the week prior to the second day of inspection. This indicated that the resident had limited opportunities to engage in meaningful activities and spent most of his time in the centre or its vicinity. Staff reported that the resident's main activity consisted of taking walks in the vicinity of the designated centre. Staff reported that the resident occasionally went to a local clothes shop and out for lunch. Staff said that the resident was encouraged to engage in household activities in the centre in the evenings to avoid sitting with nothing to do. Staff gave conflicting information about the level of support required to assist the resident go to a town. The limited activities were also reflected in the resident's personal plan where the stated goals for the year were to increase visits to the residents' home and to find more routes for walks in the vicinity of the designated centre. Staff reported that visits to the resident's home had reduced in recent months due to reasons outside of the control of the provider. However, alternative goals and activities had not been identified.

Judgment: Not compliant

## Regulation 17: Premises

The space and lay-out of the premises were suited to the needs of residents. Residents had space and suitable storage for their personal items. Equipment required by residents was available, for example, shower chairs. Residents had access to laundry facilities. However, improvement was required in relation to the upkeep of some parts of the centre. For example, the arm of a resident's couch was broken. It had been identified on an infection prevention and control audit that this would be replaced in February 2024. On the day of inspection, this had not occurred.

Judgment: Substantially 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 October 2023. At the time of the inspection, one action had been completed and two had commenced and 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, significant improvement was required in order to ensure that risks were appropriately documented and communicated to staff in order to ensure that residents received appropriate support.

The inspector reviewed the centre's risk register. This register recorded risks relating to health and safety and risks relating to service provision. The risk assessments in the register had been recently reviewed.

Each resident had a personal risk management plan that outlined a number of risk assessments relating to the individual care of each resident. The inspector reviewed

two plans. It was noted that not all identified risks had a corresponding risk assessment. For example, for one resident, there was no risk assessment in relation to swallowing yet this had been identified as a need for this resident. In addition, some risk assessments contained limited information to guide staff on how to reduce risks to residents. For example, one risk assessment did not outline all of the relevant information from the resident's behaviour support documentation.

Risk assessments were not appropriately risk rated to be reflective of the residents' needs. For example, one risk rating indicated that it was extremely likely that a resident would fall but this was not in keeping with the resident's profile and not reflected in the control measures of the assessment. The inspector also noted that a resident's personal risk management plan had not been updated in over 12 months. The PPIM opened a file on the centre's computer to show that a review had been completed in November 2023. However, the documents had not been printed out and made available to staff.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Significant improvement was required in relation to the assessment of the residents' health, social and personal needs. Improvement was also required in relation to the information provided to staff regarding the supports required by residents to meet those needs.

The inspector reviewed two residents' assessments of need and found that they were not updated annually. One assessment was completed in February 2021 and there was no record of any further update. This meant that the information may not be reflective of the needs of residents and adequate to identify the necessary supports. In addition, it was noted that some documentation was unclear and conflicting. It was not clear how decisions had been made in relation to residents' care. For example, conflicting information was contained in one resident's care plan in relation to the wearing of a falls monitor. Some documents indicted that a monitor was required while other documents outlined that the monitor was no longer needed.

Personal plans had been developed for residents. These included input from the residents' family members. However, these were not all updated within the last 12 months. One resident's plan was due for review in February 2024 but this had not occurred at the time of inspection. In addition, as outlined under regulation 13 above, the plans did not always adequately reflect goals for residents' personal development. In addition, plans had not been made available in a format that was accessible to residents.

Judgment: Not 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 June 2024. At the time of the inspection, five actions had been completed and two 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
- access to appropriate multidisciplinary team supports had been finalised and the standardised template for behaviour support plans had been finalised.

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 had been rolled out to managers with plans for staff in designated centres to received training in the coming weeks

In this centre, improvement was required in order to ensure that residents received appropriate supports to manage their behaviour.

A review of residents' personal plans indicated that information was not provided to staff in a consistent and uniform manner. For example, there was evidence that behaviour support specialists had reviewed the documentation relating to one resident and had made recommendations regarding appropriate supports. However, the resident's behaviour support plan, which was devised in January 2024, was not available in the resident's personal plan on the day of inspection. The PPIM printed the plan on the day. Additional specific support was recorded in separate documents, for example, a meeting note outlined how to support the resident to prepare for going on the bus. Again, this was saved on a computer and not accessible to staff. The information from this meeting note was not included in the overall behaviour support plan. In addition, staff reported that the support offered to this resident at night was in contrast to the guidance outlined in the behaviour support plan.

Where information was provided to staff, it was not always clear that this had been developed by a suitably qualified person and that the information had been reviewed in line with the residents' needs. For example, a resident's behaviour support plan had not been updated since February 2023 despite staff reporting an increase in self-injurious behaviours. The name of the person who devised the plan

was not recorded. Therefore, it was unclear if the required supports had been identified by an appropriately qualified person.

The provider's procedures in relation to behaviour support were not always followed. The inspector reviewed the two most recent incidents that had been reported in relation to a resident engaging in self-injurious behaviour. It was noted that the incidents had not been escalated to the behaviour support service. The PPIM reported that a general referral to the behaviour support service had been made a number of months ago for all residents. However, on the day of inspection, the behaviour support specialist had not yet reviewed the care and support of this resident.

Judgment: Not 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 October 2023. At the time of the inspection, four actions had been completed and one was in progress.

The completed actions included:

- a new system was in place to improve staff awareness of the safeguarding process. The agendas for all team meetings in the centre included safeguarding as a standing item.
- active safeguarding plans were reviewed on a quarterly basis
- a safeguarding oversight committee had been established
- the safeguarding policy had been reviewed

The action in progress included:

- face-to-face training in safeguarding had commenced but had not been rolled out to all staff. Six of 13 staff in this centre had received face-to-face safeguarding training.

In this centre, the provider had made arrangements to protect the safety of residents. There was evidence that where safeguarding incidents occurred, procedures were followed to protect residents and to prevent a reoccurrence. The residents' files contained intimate care plans that gave clear guidance to staff on how to support residents. These plans were recently reviewed. However, improvement in staff training was required, as outlined above.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

While some measures had been introduced to ensure that residents were offered choices, improvement was required in order to ensure that the rights of residents were promoted in this centre.

Discussion with staff indicated that they were aware of resident's preferences and dislikes. However, it was unclear how residents were routinely offered choices. For example, it was unclear how a resident had been supported to choose and to consent to a holiday that was planned for them a few months previously.

It was not clear how residents' consent had been sought in relation to aspects of their daily lives. For example, as outlined in the first section of the report, it was not clear if a resident had given consent for another person to access their apartment during their absence.

The PPIM and manager reported that weekly meetings with residents had commenced in the time between the two days of inspection. They reported that the purpose of the meetings was to offer choices to residents in relation to grocery shopping, meals and weekly activities. These meetings required additional time for their effectiveness to be established in the centre.

Judgment: Not 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 | Not compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Not compliant |
| Regulation 13: General welfare and development | Not compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 8: Protection | Substantially compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Forest View Apartments OSV-0001783

## Inspection ID: MON-0042971

## Date of inspection: 01/05/2024 and 16/05/2024

**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 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>• All but one staff have now completed both theory and practical FEDS modules as of 24/06/2024. The one remaining staff will complete the practical modeule on 12/09/2024<br><br>• Eight staff have now completed face to face safeguarding training and the remaining five staff are scheduled to attend events on 26/06/2024 and 02/07/2024. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• 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.<br><br>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 31/07/2024. 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.

• The registered provider has restructured the governance and oversight arrangements to increase the time available to the incoming Person in Charge for management of the service.
• The Person in Charge will ensure that oversight of audits and their completion in line with the Providers timeline through the implementation of a monthly and quarterly checklist tool.
The Person in Charge will ensure that audits are completed in recognition of each person's specific needs through the correlation of actions from each audit into a SMART action plan.

| Regulation 10: Communication | Not Compliant |
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Outline how you are going to come into compliance with Regulation 10: Communication:
• A team meeting is scheduled for the 02/07/2024 to discuss and update the communication profiles for the people supported in the service.
• All communication profiles will be reviewed, and staff will give input as to any changes to the person's communication, presentation and profile.
• The staff will update any communication strategies that are being used by the people supported. The updated profiles will be signed, dated and kept in the person's file for review by staff at any time.
• Any changes to a person's presentation and/or the strategies and communication approach used with them will be discussed at bimonthly team meetings and documented accordingly.
• Person in Charge has made referral to SLT department for support to staff to develop their understanding in this area (21/6/2024)

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| Regulation 13: General welfare and development | Not Compliant |

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The Person in Charge has introduced weekly house meetings to ensure people supported have adequate input into service provision and are afforded opportunities to express choice and control around their activities of daily living in accordance with their interests, capacities and development.
• The Person in Charge will ensure formal planning meetings for all person's supported will occur before 26/07/2024 where the idividual planning process will include the garthering of information through the "Whats important to me" and "assessment of needs" tool.
• This process will support identification of goals for personal and social development and ensure engagement in activities that are in line with their interests.
• This information will be documented in an annual action plan, made available in an accessible format, and reviewed during progress updates at 4 month intervals or sooner if required.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Person in Charge has ensured that a replacement has been ordered for broken furniture in one person's apartment. This will be delivered before 12/07/2024
• The Person in Charge is liaising with OT around the replcement of an armchair which was worn with cracked coverings on the arms. This will be replaced before 16/08/2024
A review will be undertaken in conjunction with the organization's maintenance department to agree an alternative storage solution for one resident where access to drawers was restricted due to the placement of furniture. The actions from this review will be complete before 16/08/2024

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| Regulation 26: Risk management procedures | Not 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.

• A meeting is scheduled with the Person in Charge, staff team and Behaviour Support Specialist and the Physiotherapist 02.07.2024 to discuss and update the Personal Risk Management plans and behavioural support plans for the people supported in the service.
• The updated Personal Risk Management Plans will be signed, dated and kept in the person's file for review by staff at any time.
• The Person in Charge has submitted a referral to the organisations Speech and Language Therapy department on 21/06/2024 to assess the risk in relation to swallowing for one resident and will ensure that a risk assessment with pro-active and reactive risk reduction measures is included in the persons Personal Risk Management Plan.
• All but one staff have now completed both theory and practical FEDS modules as of 24/06/2024. The one remaining staff will complete the practical modeule on 12/09/2024
• The Person in Charge will ensure that all personal plans, protocols and related documents will be reviewed at formal planning and progress update meeings, or sooner if required with named staff.
• A permanent agenda item for team meetings will be, updates to personal plans, protocols and relevant documents.

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| Regulation 5: Individual assessment and personal plan | Not Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The Person in Charge will ensure formal planning meetings for all person's supported will occur before 26/07/2024 where the idividual planning process will include the garthering of information through the "Whats important to me" and "assessment of needs" tool.
• This process will support identification of goals for personal and social development and ensure engagement in activities that are in line with their interests.
• This information will be documented in an annual action plan, made available in an accessible format, and reviewed during progress updates at 4 month intervals or sooner if required.
• A meeting is scheduled with the Person in Charge, staff team and Behaviour Support

Specialist and the Physiotherapist 02/07/2024 to discuss and update the Personal Risk Management plans and behavioural support plans for the people supported in the service.

• The updated Personal Risk Management Plans will be signed, dated and kept in the person's file for review by staff at any time.

| Regulation 7: Positive behavioural support | Not Compliant |
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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.
• A meeting is scheduled with the Person in Charge, staff team and Behaviour Support Specialist and the Physiotherapist 02/07/2024 to discuss and update the Personal Risk Management plans and behavioural support plans for the people supported in the service.
• The updated Personal Risk Management Plans will be signed, dated and kept in the person's file for review by staff at any time.
• The Person in Charge will ensure that all incidents requiring behavioral support input are escalated to the relevant behavioral support practitioner and that a review is planned following each quarterly incident analysis.
• The Person in Charge will ensure that all personal plans, protocols and related documents will be reviewed at formal planning and progress update meeings, or sooner if required with named staff.
• A permanent agenda item for team meetings will be, updates to personal plans, protocols and relevant documents.

| Regulation 8: Protection | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
• Eight staff have now completed face to face safeguarding training and the remaining five staff are scheduled to attend events on 26/06/2024 and 02/07/2024.

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| Regulation 9: Residents' rights | Not Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The Person in Charge will ensure that all staff complete, Applying a human rights-based approach in health and social care: Putting standards into practice on HSEland before 05/07/2024.
• The Person in Charge has introduced weekly house meetings to ensure people supported have adequate input into service provision and afforded opportunities to express choice and control around their activities of daily living in accordance with their interests, capacities and devleopment.
Discussions will be held at the weekly house meeting to establish consent around visitors accessing their apartment.

## 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 |
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| Regulation 10(2) | The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan. | Not Compliant | Orange | 02/07/2024 |
| Regulation 13(2)(a) | The registered provider shall provide the following for residents; access to facilities for occupation and recreation. | Not Compliant | Orange | 26/07/2024 |
| Regulation 13(2)(b) | The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental | Not Compliant | Orange | 26/07/2024 |

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| | needs. | | | |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Not Compliant | Orange | 12/09/2024 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 16/08/2024 |
| 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 | 26/07/2024 |
| 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 | Not Compliant | Orange | 12/09/2024 |

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| | system for responding to emergencies. | | | |
| Regulation 05(1)(b) | The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis. | Not Compliant | Orange | 26/07/2024 |
| Regulation 05(2) | The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1). | Not Compliant | Orange | 26/07/2024 |
| Regulation 05(5) | The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative. | Not Compliant | Orange | 26/07/2024 |
| Regulation 05(6)(b) | The person in charge shall ensure that the personal plan is the subject of a review, carried out | Not Compliant | Orange | 26/07/2024 |

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| | annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability. | | | |
| 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. | Not Compliant | Orange | 02/07/2024 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 02/07/2024 |
| Regulation 08(7) | The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. | Substantially Compliant | Yellow | 02/07/2024 |

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| Regulation 09(2)(a) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support. | Not Compliant | Orange | 05/07/2024 |
| Regulation 09(2)(b) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life. | Not Compliant | Orange | 05/07/2024 |
| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | Not Compliant | Orange | 05/07/2024 |