Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	Woodbeg
Name of provider:	St Catherine's Association CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	30 April 2024
Centre ID:	OSV-0003409
Fieldwork ID:	MON-0042535

About the designated centre

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

Woodbeg is a designated centre operated by St. Catherine's Association in Co. Wicklow. Woodbeg provides full-time residential care for two young adults with a diagnosis of autism and intellectual disabilities. The centre is a four-bedroomed bungalow set on a large site with a garden to the front and rear. A full-time person in charge is appointed to the centre and they are supported in their role by a deputy manager and social care workers. The person in charge divides their time between this centre and one other designated centre. Transport resources are assigned to the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 30 April 2024	08:00hrs to 15:30hrs	Sarah Cronin	Lead
Tuesday 30 April 2024	08:00hrs to 15:30hrs	Jennifer Deasy	Support

What residents told us and what inspectors observed

From what residents told us and what inspectors observed, residents were well supported to engage in activities of their choosing in line with their expressed preferences. Overall, this inspection found mixed levels of compliance with the regulations, with some areas of good practice found in relation to staffing and residents' general welfare and development. However, improvements were required in fire precautions, in positive behavioural support, in governance and management and in training and staff development. These will be discussed in the body of the report.

The designated centre is a bungalow located in a rural setting in County Wicklow and was home to two residents at the time of inspection. Both residents presented with complex behaviour support needs related to their diagnosis. The house comprises a large kitchen, a sitting room, a conservatory area, a utility room, two resident bedrooms, one of which had an en suite, a staff office/ sleepover room and another small relaxation room. There were two further bathrooms and an en suite available in the centre. The provider had recently completed a renovation to one of the centre's sitting rooms. This was seen to be comfortable and provided a quiet space for residents to relax in. The house was found to be clean and well maintained, and had ample private and communal facilities available for residents. Recent photographs of residents were displayed on the wall. These photographs showed residents attending funfairs, fun runs and other community activities. While the premises was comfortable and well-maintained, the inspectors saw that there were some risks to the safe evacuation of residents in the event of an emergency. This is discussed later in the report under Regulation 28: Fire Precautions.

Inspectors had the opportunity to meet with both residents over the course of the inspection. Residents in the centre communicated in a number of ways which included speech, Lámh, vocalisations, body language and behaviours. Residents required staff who were supporting them to be familiar with them, and in turn, to be able to recognise and respond to all forms of communication in a clear and consistent way. A speech and language therapist attended the centre and saw each resident for an individual therapy session. The inspectors saw that staff supported and facilitated these appointments. Staff reported that residents' communication skills had been enhanced and that they were seeing a positive impact as a result of the speech and language therapy input. The inspector saw positive and friendly interactions between residents and staff. One resident asked staff about their lunch options. Staff responded positively to the resident's requests for pizza for lunch and the resident smiled when they were told that pizza was available. The inspector saw staff responding positively to residents' non-verbal interactions. For example, inspectors saw residents and staff exchanging smiles, winks and high-fives.

On arrival to the centre, one resident greeted inspectors at the door. Both residents were going about their morning routines. Residents were seen to be very comfortable and relaxed in their home. Both residents came into the staff office on

the morning of the inspection and engaged with the inspectors through both verbal and non-verbal means. One resident gave the inspectors a thumbs-up and asked staff about their breakfast. Staff responded to the resident in a reassuring manner and assisted them with preparing their breakfast. The other resident came into the staff office to get their morning medications, with the assistance of staff. This resident greeted the inspectors and was seen to be relaxed and familiar with the staff who was supporting them. One of the residents requested an inspector to go and speak with them at breakfast time, and again during the day. They spoke about their routine and about staff working in the centre and who was on duty. The resident drew and used a tablet device in addition to speech. Staff were available to facilitate and support this discussion. The resident communicated using speech, drawing and gestures. It was clear to inspectors that understood the resident's modes of communication and responded in a reassuring and calm manner to them throughout the day.

Since the last inspection, the provider had implemented a number of safeguarding measures in the centre to reduce the impact of behavioural incidents on a peer. This included each resident having two assigned staff members , two new vehicles, renovating a spare bedroom to become an additional relaxation space, and one resident relocating their bedroom in the centre. One of the residents showed the inspector their new bedroom, which was nicely decorated in line with the resident's personal preferences. The resident's possessions were neatly displayed and were available to them. There was sufficient storage for the resident's belongings. Staff told the inspectors that the designated centre had recently been provided with a new bus and a new car. These vehicles were supporting residents to access their community frequently and in line with their assessed needs and preferences. On the afternoon of the inspection, one resident had made plans to go for a walk in a nearby town. Staff spoke about the importance of routine for residents and about how they ensured that residents' routines were facilitated.

A review of residents' care plans showed that residents engaged in a number of activities of interest to them which included going on long walks, going out for a meal or an ice-cream, attending a day service and both residents had recently commenced personal training in a local gym. One resident was attending college and also enjoyed swimming, walking and shopping. One of the residents had recently joined a local soccer club and was attending matches. They had recently attended a rugby game with staff and was supported to tell the inspector about it.

Staff had completed training in human rights. Inspectors had the opportunity to meet with three staff, who spoke about how the training 'made them think' and how they approached offering choices to residents in a different way since completing the training. They spoke about trying to develop residents' independence and their skills in activities of daily living. Residents were supported to maintain their autonomy in respect of their daily activities. For example, residents were prompted to put their bowls and cups away in the dishwasher when they had finished. Residents were also gently prompted by staff to complete personal care, such as brushing their teeth. Staff spoke about how one of the residents had successfully had their hair cut in a hairdressers recently, which was a significant achievement. They were now administering their own medication after their skills were developed

with staff support. The provider demonstrated an increase in awareness of residents' rights by recognising and reporting incidents which involved residents' right to freedom of movement being affected by the behaviour of a peer. For example in quarter three of 2023, there had been five incidents of such a nature occur. These were being addressed under safeguarding measures.

Residents were supported to have input into the running of their home through residents' meetings. A set agenda was in place for staff to use with residents as part of a monthly meeting. This included activities, likes, dislikes, meal planning and complaints. External advocacy had been accessed by one of the residents since the last inspection and the inspectors viewed correspondence between the advocate and the provider on the resident's behalf.

Overall, residents were well supported in their home and it was evident that the staff on duty on the day of the inspection were endeavouring to ensure that they had a good quality of life and that they continued to develop skills to enable them to become more independent. The next two sections of the report present the inspection findings in relation to the governance and management of the centre, and how governance and management affects the quality and safety of the care and support being delivered.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. There were management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' assessed needs. However, improvements were required in staff training and development, in governance and management, positive behavioural support and fire precautions.

This inspection was an unannounced inspection scheduled in order to monitor ongoing regulatory compliance. The centre had two inspections carried out in 2023 due to notifications of concern relating to safeguarding. This had resulted in a cautionary meeting taking place with the provider in November 2023. The provider submitted a compliance plan which gave assurances on the measures the provider would take to come back into compliance. The compliance plan formed some of the lines of enquiry for this inspection.

Overall, the inspectors found that that there were oversight arrangements in place at provider level in order to ensure the quality and safety of care. The inspectors were not wholly assured that the local management systems were ensuring that the service was consistently and effectively monitored.There was a management structure in place, whereby staff reported to the person in charge, who in turn

reported to the person participating in management. The person in charge had a dual role, and was person in charge for another designated centre nearby. They reported that a deputy person in charge was recruited and due to commence in the weeks following the inspection. However, on the day of the inspection, it was evident that due to a gap in oversight arrangements, there was not adequate monitoring and oversight in place to ensure that risks were identified and escalated and that required documentation was maintained. This is discussed further under Regulation 23: Governance and Management below.

The provider had recently increased the staffing complement in the centre. Inspectors saw that the residents were supported by a familiar and consistent staff team. There were sufficient staff on duty to provide individualised care and support to the residents in line with their assessed needs and preferences. Staff had completed training in key areas however there a number of staff required refresher training. This is discussed under Regulation 16: training and staff development below.

Regulation 15: Staffing

The inspectors observed that there were sufficient staff on duty to meet the assessed needs of the residents and to provide care in an individualised and person-centred manner. The provider had recently increased the total staffing complement in the centre and the inspectors were told that this was having a positive impact on the residents. It was reported that there had been a reduction in the number of adverse incidents involving residents and residents were reported to be more comfortable in their home and in each other's company. Inspectors saw that residents were supported by a familiar staff team who knew the residents and their needs well. Staff members on duty on the day of the inspection were found to provide support to residents in a gentle and respectful manner.

The inspectors reviewed the rosters from the four weeks preceding the inspection. The rosters showed that the number of staff was appropriate to the number and assessed needs of the residents and was in line with the statement of purpose. There was a small panel of regular relief and one agency staff employed in order to fill gaps in the roster. This was supporting continuity of care for the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff in this centre told the inspectors that they felt well-supported and that they were in receipt of supervision from the person in charge. The inspectors found that the supervision records had not been maintained in a manner which allowed

inspectors to verify that supervision had been completed in line with the provider's policy. Inspectors asked to review the supervision records for staff. However, these were unavailable to review. The person in charge reported that these were in the process of being archived. It was therefore not possible to verify that supervision had been completed in line with the provider's policy.

A training matrix was reviewed on the day of inspection. Inspectors saw that staff had completed training in key areas including fire safety, safeguarding vulnerable adults and infection prevention and control. Staff had also completed required training to meet residents' assessed needs, for example in anaphylaxis. All staff had completed four modules of the Health Information and Quality Authority's (HIQA) Human Rights Based Approach Training.

A small number of staff were awaiting refresher trainings. These included three staff who were awaiting first aid training and two staff who were awaiting Safety Intervention training. The inspectors were told that some of these trainings had been scheduled for the coming weeks.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre. However, the inspectors found that there was a gap in the management structures which was having a negative impact on the day-to-day monitoring and oversight arrangements in the centre.

The person in charge of the centre was a dual person in charge, and had responsibility for another designated centre nearby. The centre had been without a deputy client services manager for some time. This was resulting in reduced local oversight of the day-to-day running of the centre as the person in charge was not always on-site due to their additional duties in the other designated centre and in attending off-site meetings. The impact of this was that there were a number of risks, for example in fire containment, which had not been identified on provider's audits or controlled for on a day-to-day basis. Additionally, there were gaps in the maintenance of local paperwork, for example in staff supervision records and the emergency folder. Staff meetings had not always occurred monthly as required. For example, staff meetings in February and December were cancelled. The inspectors were told that a deputy client services manager had been recruited and was due to commence in the centre in the coming months. The provider expressed that this would be effective in enhancing the local management systems.

The provider had completed six-monthly unannounced visits and an annual review of the quality and safety of care. These were completed in consultation with the residents in line with regulatory. Actions identified on these audits were inputted on a tracker where to ensure that actions were completed in a timely manner.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. Overall, the welfare of residents in the centre was maintained by a good standard of care and support. However, improvements were required in positive behavioural support and in fire precautions.

Residents in the centre had personal plans in place which included plans in relation to health, behaviour support, personal care, activities and communication. Communication supports were in place to ensure that residents were facilitated to communicate using a method of their choice. As previously outlined, residents were busy doing a range of activities, both independently of one another, and together where they chose to do so. Since the last inspection, the provider had implemented a number of safeguarding measures in the centre to reduce the impact of behavioural incidents on a peer. These are detailed under Regulation 8: Protection below. Positive behaviour support plans were in place. However, additional improvements were required to ensure that the provider's policy on the use of restrictive practices were in line with best practice, and that there were clear arrangements in place for ensuring that restrictive practices were used for the shortest duration of time.

Inspectors found that the premises had been upgraded since the last inspection, which meant that there was now an additional sitting or relaxation room for residents to use. The environment was found to be clean and well maintained.

There were a number of fire safety risks identified over the course of the inspection. The inspectors issued an immediate action on arrival to the centre as two fire doors were seen to be wedged open. This posed a risk to the fire and smoke containment systems in the centre. Staff removed and disposed of these wedges. Other risks were seen in relation to the safe evacuation of residents. These are detailed further under Regulation 28: Fire precautions below.

Regulation 10: Communication

As outlined at the beginning of the report, residents in the centre presented with autism and complex communication support needs. Both were in receipt of speech and language therapy. Inspectors reviewed residents' personal plans which had communication strategies outlined. Communication plans included information on 'what makes me happy', 'what makes me anxious', the phrases which residents regularly used , what they meant and how to respond. One of the residents had an interaction protocol in place to ensure that a consistent approach was taken by all

staff to support the resident. Inspectors reviewed the residents' communication support plans and their behaviour support plans. Staff were observed to use a low arousal approach to interactions and responded in a kind, gentle and friendly manner to residents.

Judgment: Compliant

Regulation 13: General welfare and development

From a review of care plans and progress notes, it was evident that both residents were supported to engage in a number of meaningful activities in line with their assessed needs and expressed preferences. They were able to access activities and place of interest independently of one another due to a change in the allocation of staff and additional transport being available. Residents had commenced personal training in a gym, one of them was attending a day service, they were going on walks independently of one another, and together. There were photographs on the wall of residents completing fun runs and enjoying a fun fair. One of the staff members spoke about supporting a resident to work towards staying in a hotel overnight.

Residents were supported to maintain relationships with family members through family access visits, video calls and visits to the house.

Judgment: Compliant

Regulation 17: Premises

Inspectors carried did a walk around with the person in charge and found that the designated centre was homely, clean and well maintained. Residents each had their own bedroom. One resident showed the inspectors around their bedroom and appeared to be proud of it. The inspectors saw that it was individually decorated in line with the resident's preferences. Another resident had recently been supported to move their bedroom to another room further down the corridor. They showed one of the inspector their new bedroom which was nicely decorated and reflective of their interests.

There was plenty of communal space available to residents including two sitting rooms, a conservatory and a kitchen and dining room. Works had recently been completed to one sitting room in order to make it more homely. This room was furnished with comfortable bean bag style chairs and a TV. Recent photographs of residents were displayed on the walls. The other sitting room contained games, jigsaws and exercise equipment.

One resident had their own en-suite bathroom. The other resident had access to a large bathroom located beside their bedroom. Both bathrooms were clean and well-maintained.

There was sufficient storage in the house for residents' personal belongings and residents' also had access to laundry facilities in order to launder their clothes.

Judgment: Compliant

Regulation 28: Fire precautions

The fire management systems in the centre required a review by the provider. The inspectors found that there were a number of risks to the containment of smoke and fire and to the safe evacuation of residents. Actions were taken by the provider to address some of these risks on the day of inspection however, overall, the fire management systems required further consideration.

The inspectors issued an immediate action on arrival to the designated centre as two fire doors were observed to be wedged open. Staff were asked to remove these wedges and dispose of them. The inspectors also saw that the three designated emergency exit doors were key-locked and had the potential to delay a prompt evacuation of the centre in the event of a fire. The provider's maintenance team attended the centre on the day of the inspection and fitted thumb lock mechanisms to the doors in order to mitigate against this risk.

The inspectors reviewed a fire safety report which had been completed by an external expert in 2019. The fire safety report recommended that door holders be installed on the office door and that thumb locks be installed on emergency exit doors. The inspector was told that a door opener had been installed on the office door but was removed and was not re-fitted when the office was moved to a different room. The inspectors were also told that there had been a risk of absconding in 2019 which was the rationale for not fitting thumb locks. However, the inspectors could not see evidence that alternative measures such as swipe card or code access, as recommended by the fire safety report, had been trialled. Additionally, the resident profile had changed since 2019 and there was no longer a risk of absconding in the centre. The inspectors were told that the provider had recently commissioned another fire safety audit and were awaiting this report to inform their fire safety plan.

Residents each had a personal evacuation plan however these were not readily available in the centre's emergency folder or their person centred planning folder. The person in charge printed a copy of these from the provider's online system. The inspectors reviewed these and found that they required review as they did not accurately describe the minimum number of staff required to evacuate the residents during an emergency.

The inspectors found that the provider's policy on the management of serious and

adverse events did not provide guidance to staff on the frequency of fire drills to be completed, including night-time drills. Additionally, there was a lack of guidance for staff in managing risk where night-time drills had the potential to result in adverse events for residents.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors reviewed the restrictive practice policy, a draft of the updated policy on positive behaviour support, residents behaviour support plans and behaviour incident forms. Inspectors found that both of the residents' behaviour support plans had been reviewed since the last inspection and residents had regular input from a behaviour support specialist. The positive behaviour support plans listed proactive and reactive strategies for staff to use with each resident and had clear protocols in place in relation to night time routines and interaction protocols. For one restrictive practice used on transport, there was criteria in place for staff to consider for reducing that restriction over time in line with the residents' presentation. However, reactive strategies in relation to the use of physical holds remained unclear. The behaviour support plan had reference to staff using training on the use of physical interventions. However, there remained a lack of clarity on what holds were or were not acceptable in line with the provider's policy on restrictive practice. Inspectors found the same guidance in relation to physical holds was in both behaviour support plans. However, physical holds only in use with one resident. This was a repeat finding from the last two inspections.

The restrictive policy was last reviewed in 2019, and inspectors found that was not in line with current guidance, changes in legislation and best practice in order to inform the quality and safety of care and promote autonomy and rights of the residents. For example, the policy had a list of various restrictive practice measures, but it did not give clear guidance on what restrictive practices were not acceptable within the organisation. The policy was not clear on what was required of staff and management following use of any physical holds, or any emergency restrictive practices. On review of the staff training matrix, it was evident that staff had received training in Safety Intervention techniques annually. However, the safe use of physical holds were not practiced by the team in the interim period in line with the provider's policy. This meant that the provider could not be assured that where physical holds were used, that they were proportionate to the incident, that they were used for the least amount of time, that staff judgment on the use of holds was consistent, and that holds were carried out correctly in line with the training provided. This, coupled with unclear guidance for staff in behaviour support plans, remained a concern.

There was evidence that the behaviour specialist had identified the need for an improvement in report writing in relation to behavioural incidents and a staff meeting had occured in January of this year. However, the inspectors found that

there remained gaps in documentation relating to behavioural incidents. For example, one incident had no start time on it and in two incidents reviewed, staff used a physical hold. However, it was not clear how long this was used for and what review took place to ensure that this was an appropriate response from documentation provided. Without clarity in recording incidents and the follow up occuring, the provider could not be assured that they could accurately monitor these incidents and put additional measures in place where they were required.

Judgment: Not compliant

Regulation 8: Protection

As outlined at the beginning of the report, the provider had put a number of control measures in place to safeguard residents and ensure that each resident was not impacted upon by the behaviour of another. These measures included additional staffing, additional transport and a reconfiguration and refurbishment of some bedrooms. Inspectors noted that there had been a reduction in the number of notifications submitted to the Authority. Inspectors viewed documentation and correspondence with the HSE in relation to any incidents which had occured and found that these incidents had been managed by the provider in line with national policy.

Residents had intimate and personal care plans in place which gave clear guidance to staff on the level of support each resident needed and which ensured each residents' right to autonomy, privacy and dignity were promoted and upheld during these care routines.

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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Woodbeg OSV-0003409

Inspection ID: MON-0042535

Date of inspection: 30/04/2024

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Supervision record keeping a. SCA policy states that "Written notes of the supervision meeting should be recorded at the end of the session using SCA supervision template form". SCA policy also states that a scanned record of the session should be saved "into [a] secure location supervision file on the shared drive …" b. The Head of Operations will meet with the Person-In-Charge to outline the responsibilities of SCA's supervision policy, and ensure that supervision sessions are recorded following each session, and that scanned copies are made available to the supervisee, and stored in a secure location on SCA's shared drive. To be completed no later than 28th June 2024. 2. Staff training a. Three staff members require First Aid Training. All three will have completed first aid training no later than 13th November 2024. b. Two staff members require Safety Intervention training. One staff member attended training on 15th May 2024. The second staff member is scheduled to attend Safety Intervention training no later than 25th June 2024.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Deputy Residential Service Manager	

a. A Deputy Residential Services Manager [DRSM] is due to commence in Woodbeg on 17th June 2024 increasing local day-to-day oversight of Woodbeg, and enhancing local management systems. The Person-In-Charge, and the DRSM will co-ordinate their work schedules to ensure a management presence on-site for the majority of the week.
2. Risk Management
a. SCA commit to the Quality Compliance Officer cross-referencing their audit protocols with the new HIQA Fire Safety guidance updated as of September 2023. This will completed from the remaining Provider 1 audits, and for all provider-led audits moving forward. Complete no later than 28th June 2024.
b. SCA commit to completing a review of daily / weekly housekeeping internal audits to ensure that fire safety risks are identified and addressed in timely manner. Review to be completed no later than 28th June 2024.
3. Paperwork
a. The appointment of a DRSM, as of 17th June 2024, will provide an additional managerial resource to Woodbeg to ensure that gaps in paperwork are identified, and addressed in a timely manner.
b. Re: Staff supervision records; please see corrective action under reg. 16.
c. Re: Emergency folders; please see corrective action under Reg. 28.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Fire Safety Review
a. SCA engaged a fire safety consultant to conduct a full and independent Fire Safety Audit of Woodbeg in February 2024. SCA received the final audit report for Woodbeg on 7th May 2024. SCA will implement all recommendations within the Fire Safety Audit no later than 27th September 2024.
b. SCA acknowledge the use of door wedges on the day of inspection. Door wedges were removed immediately. SCA commit to updating daily / weekly housekeeping audits to include a visual check to ensure that door wedges are not being used. To be completed no later than 28th June 2024.
c. Key-locked emergency doors had their locking mechanism replaced with a thumb-lock alternative on the day of inspection. Complete; 30th April 2024.
d. SCA commit to ensuring that each individual�///s emergency support plan is stored in centre’s emergency folder. Complete; 28th June 2024.
e. SCA commit to completing a full review of emergency support plans, and updating to include the minimum staffing ratios needed to safely evacuate during an emergency; no later than 28th June 2024.
2. Policy
a. SCA Policy Framework Policy allows for existing policies to be revised to reflect regulatory and policy changes outside of the standard review period, therefore SCA’s Head of Operations will complete policy Change Control Form requesting an advance review of the Serious Incident and Adverse Event policy to include guidance to staff on the frequency of fire drills to be completed, including night-time drills, and guidance for

staff in managing risk where night-time drills has the potential to result in adverse events for residents. The HOO will complete the change request form and submit to the Senior Management Team for consideration no later than 28th June 2024.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. Policy
a. SCA's Restrictive Practice policy is currently under review. The current review has taken into consideration recent updates in legislation, current best practice, and provides guidance on what restrictive practices are not acceptable in SCA, and on what staff & management are required to do post-physical holds. The Restrictive Practice policy is due to be presented to the Board of Directors in July 2024 for approval.
b. Upon the new Restrictive Practice policy being Board approved, SCA will implement quarterly practice sessions as part of scheduled team meetings. Staff teams will refresh the skills they have learned annually through Safety Intervention training. Complete no later than 27th September 2024.
2. Use of Physical Holds
a. All CPI trained staff receive workbooks as part of training which provide visual reminders of the physical holds, ensuring familiarity and competence in the use of physical skills. Also, all SCA CPI Trained instructors have access to the physical skills videos available via their personal My Account on the CPI website. Complete; 30th April 2024.
b. SCA have an expectation that all CPI trained employees will respond to each incident appropriately based on the specific context and risks presenting to the individual and those in the environment. Where necessary, staff will implement the least restrictive intervention, for the shortest duration, in line with training provided. SCA routinely monitor the use of restrictive practices every fortnight, by the PIC & Positive Behaviour Support Specialist, and each quarter by the Quality Compliance and Training Department.
3. Behaviour Support Plans
a. SCA commit to reviewing and updating individual positive behaviour support plans to provide context specific staff guidance relevant to the individual, and the appropriate use of physical holds as a last resort, including emergency use and associated escalation processes for review with relevant stakeholders. To be completed no later than 27th September 2024.
4. Training
a. SCA's Quality Compliance & Training department will identify report writing training to be provided to all Woodbeg staff. Training to be provided no later than 20th December 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 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.	Substantially Compliant	Yellow	13/11/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/06/2024
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	28/06/2024
Regulation 28(1)	The registered	Not Compliant	Orange	27/09/2024

	provider shall ensure that effective fire safety management systems are in place.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	30/04/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	28/06/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	28/06/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used,	Not Compliant	Orange	26/07/2024

	such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	27/09/2024