Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St Francis Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	31 July 2024
Centre ID:	OSV-0001774
Fieldwork ID:	MON-0043881

About the designated centre

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

St Francis Residential Service is a designated centre which supports residents with a low to moderate intellectual disability. The centre can also support residents with mental health needs and residents who require some medical interventions. A social care model of care is provided in the centre and residents are supported by both social care workers and social care attendants. Additional staffing is deployed during the week day evenings to facilitate residents to engage in community activities and a sleep-in arrangement of one staff member is used to support residents during night-time hours.

The centre is a large sized two-storey building which is located with walking distance of a large town. Each resident has their own bedroom and there is ample shared living space for residents to have visitors in private, if they so wish. There is also a large patio area for residents to enjoy and there is transport available for residents to access the community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 31 July 2024	12:00hrs to 17:30hrs	Mary McCann	Lead
Thursday 1 August 2024	10:00hrs to 13:15hrs	Mary McCann	Lead

What residents told us and what inspectors observed

This centre is run by Western Care Association in Co. Mayo. Due to concerns about the governance and oversight of Western Care Association centres and its impact on the well-being and safety of residents, the Chief Inspector of Social Services undertook a targeted safeguarding inspection programme over two weeks in March 2023 which 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 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 commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, and to assess whether the actions of Western Care Association have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Mayo. At the time of this inspection the majority of actions had been implemented, with the remaining in progress. The provider had made improvements in their governance and management arrangements, including the management of safeguarding residents, positive behaviour support and risk. An update on each of the areas focused on as part of the targeting programme is contained in this report.

St Francis residential services is registered to provide full time residential care to five residents. There were five residents living in the centre at the time of this inspection. This unannounced inspection was carried out as part of the Chief Inspector's regulatory monitoring of the centre and to assist with assessing whether this centre was suitable for renewal of registration. Registration of a designated centre with the Health Information and Quality Authority must be renewed at three yearly intervals. From engagement with residents who were living in the centre at the time of this inspection, observations in the centre by the inspector and reviewing information, the inspector found that this was a happy, busy household. The inspector spoke with all five residents who were complimentary of the service provided to them and the care and support delivered to them by the staff team. Residents who were able to converse with the inspector told the inspector that they 'were happy living in the centre" and "all staff treated them well". Residents were facilitated to pursue activities of their choice in their local community by attending day services and engaging in other activities with staff of the centre. The centre had access to transport and residents told the inspector that they regularly went to various local events in the evenings after returning from day services and having their dinner, for example the gym, a run with staff, or the cinema. There was good evidence of regular contact with residents' families and one resident went home regularly.

There was a large sitting room with comfortable furniture, a dining room and kitchen. The centre offered a comfortable area for residents to sit and relax on

return for day services. A large patio area with garden furniture was available to the back of the premises which was easily accessible from the living area. The inspector observed when residents returned from the day services, that they were excited to see staff who greeted them warmly and spoke about their day at the day services. One resident recently had a birthday party and was delighted to tell the inspector how much they enjoyed having a party and how the staff helped to arrange the party. The inspector observed good comradeship between staff and residents which added to a pleasant homely atmosphere in the house. Staff had undertaken training in human rights and they told the inspector this made them more aware of the importance of rights for residents.

St Francis consists of a large two storey house located in a residential area, close to a busy town, which gave residents good access to a wide range of facilities and amenities including, a wide range of shops, cafés parks, theatre and beaches. Each resident had their own bedroom and there was adequate shower and toilet facilities. The house was clean and homely. There was information available in the house in an easy-to-read format on areas such as, safeguarding and advocacy. Staff spoken with had spent many years working for the services and displayed a good knowledge of residents' likes and dislikes.

In summary, from what the inspector observed, from speaking with staff and the residents, and reviewing documentation, the inspector was assured that residents enjoyed a good quality of life and had access to meaningful activities. They were supported by a caring, consistent staff team who listened to them and included them in decision making about their care and support.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of care and support provided to the residents.

Capacity and capability

The provider had measures in place to ensure that this centre was well managed. These arrangements ensured that a good quality and safe service was provided to residents. Areas that required review included ensuring the staff rota accurately reflected the staff on duty and ensuring all staff training was up to date.

There was a clear organisational structure in place to manage the centre. This included a suitably qualified and experienced person in charge. The person in charge was responsible for this centre, a sister respite service which was located in very close proximity and another local individualised service. Throughout the inspection the person in charge was very knowledgeable regarding the individual needs of residents and it was clear that she was known by residents and was actively engaged in the running of the centre. The person in charge had supervision with her line manager at six weekly intervals and regular regional person in charge meeting

were occurring. These had a briefing and education focus and the person in charge stated she found this meeting very valuable. The agenda for the centre staff meeting was similar to both these meetings and there was good evidence that the person in charge was informing the staff of improvements made and those that continued to be made from the provider's targeted programme. When the person in charge was not available there were clear structures in place to support staff which included an on-call system which staff were aware of and contact details of personnel on call were displayed in the centre.

The centre was suitably resourced to ensure the effective delivery of care and support to residents. These resources included the provision of suitable, safe, clean and comfortable environment, adequate staffing levels to support residents in both their leisure and healthcare needs, and a transport vehicle for the centre. A range of healthcare professionals, including speech and language therapy, physiotherapy, and behaviour support staff were available to support residents as required. The inspector reviewed the compliance plan from the last inspection of this centre which was an unannounced monitoring inspection to review compliance with the regulations relating to the care and welfare of people who live in designated centres and was carried out on the 8 November 2024. All actions had been addressed with the exception of one relating to the resurfacing of the front driveway. Actions relating to nutritional care records, resident contracts for the provision of services, staff training, information regarding the management of infected linen, and training in management of behaviour positive behaviour support and protection of residents had been addressed.

The provider had also submitted a compliance plan in response to the findings of a provider-wide targeted inspection programme in March 2023. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in this centre. These included improvements to the management team structure, reconfiguration of regions within the organisation's geographical setting and review and improvement to the overall auditing systems in the organisation. The person in charge discussed how the compliance plan was being implemented and explained some of the improved systems that had been introduced as part of this plan, including better governance which resulted in better communication to staff, enhanced auditing and better support and training for staff, resulting in positive outcomes for residents. There was improvement to the overall organisational management processes which included a range of governance and oversight meetings, the appointment of service heads for safeguarding, quality, clinical care and facilities. For example a head of quality, safety and service improvement had been appointed and was actively engaging with persons in charge in the organisation. Additional multidisciplinary supports had been appointed and these specialists were also actively involved in the delivery of specialist services to residents and support to front line staff.

Additional improvements to ensure consistency of approach, and stronger auditing and review systems had been developed and were occurring. The management structures, reporting relationships and stronger management communication had also been introduced. Some of these were still in the process of being embedded in the centre.The person in charge stated that improvements had occurred to the

overall governance in the organisation and therefore also in this centre, through shared learning, clearer processes, better support from management and enhanced oversight of the service provided.

The provider ensured that the service was subject to ongoing monitoring and review to ensure that a high standard of care, support and safety was provided to residents. Unannounced audits of the service were carried out at six monthly intervals on behalf of the provider, by personnel independent of the service which focused on the safety and quality of care and support provided in the centre. The most recent one was dated 17 April 2024. A plan was put in place to address any concerns raised in these visits. An annual review of the quality and safety of care and support in the centre which focused on ensuring the care and support provided was in accordance with the national standards for residential services for children and adults with disabilities. While a quality improvement plan had been completed post this review it was difficult to track completion of actions identified as while timelines had expired there was no narrative to support what actions had been under taken. The person in charge told the inspector that they was actively working to address any concerns identified, for example replacing the tarmac at the front of the house, getting the living room ceiling painted. The most recent annual review was completed on the 3 January 2024.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted the required information with the application to renew the registration of this designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a person in charge who worked full-time and had the qualifications, skills and experience necessary for the duties of the post.

Judgment: Compliant

Regulation 15: Staffing

The inspector observed that the residents received assistance and support in a timely and respectful manner during the inspection. The provider ensured that the number and skill-mix of staff was appropriate for the needs of residents. However, the staff rota did not accurately reflect the staff on duty in the centre. For example,

the person in charge's working hours in the centre were not recorded. Additionally staff of the respite service were detailed on the rota.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to appropriate training, including refresher training, as part of a continuous professional development programme. While mandatory training was up to date for most staff, two staff had not attended face to face refresher training in safeguarding. A schedule of staff supervision and performance management was in place. The person in charge had completed a training needs analysis for all staff and this included the health profile of residents.

Judgment: Compliant

Regulation 22: Insurance

The provider had a contract of insurance in place that met with the requirements of the regulation.

Judgment: Compliant

Regulation 23: Governance and management

This regulation formed part of the review of the targeted safeguarding programme action plan.

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

The completed actions included:

- The restructure and appointment of new senior management posts
- A reconfiguration of service areas
- The development of a service improvement team
- Un-announced provider visits by personnel independent of the centre
- A review of policies

- Regular regulatory training events
- The re-establishment of a human rights committee.
- A new induction training programme for new staff was developed and was in practice.
- The staff training and development plan had been implemented.
- A standardised monthly reporting template had been developed.

Actions in progress but not yet completed:

- A review of front line management was on-going, including a review of out of hours on call arrangements.•
- A review of the current suite of audits was in process

Completion of these actions has enhanced the monitoring and oversight of the centres. The person in charge was complimentary of the changes in governance since the commencement of the enactment of the actions from the targeted programme.

On this inspection the inspector found that the provider had ensured that there was a defined management structure in place with clear lines of authority and accountability. A planned auditing calendar was in place with regular auditing undertaken by the person in charge. Audits undertaken included health and safety, finances, medication and fire safety. Six monthly unannounced visits of the centre were being completed by the provider as these are mandatory as part of the governance and management of the centre by the provider. While a quality improvement plan had been completed post this review it was difficult to track completion of actions identified as while timelines had expired there was no narrative to support what actions had been under taken.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which was subject to regular review and was in line with the requirements of Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents occurring in the centre and the Chief Inspector was notified of the occurrence of incidents in line with the requirement of the regulation.

Judgment: Compliant

Quality and safety

Overall the inspector found that residents enjoyed a good quality of life. This service had a good level of compliance with regulations relating to the quality and safety of care provided to residents and residents were supported to live a life of their choosing. However one area that required improvement related to completion of fire drills to ensure the continual safety and protection of residents. Fire drills were occurring at suitable intervals and records were available of these drills. They outlined the scenarios under which evacuation took place including the location of residents and staff at the time of the drill, and what exit was used but did not reflect whether the personal emergency evacuation plans (PEEPs) were used and if they were effective or required review. Additionally it was not apparent if regular simulated drills were occurring when the least amount of staff were on duty to ensure that fire drills were effective at all times particularly at night time. Another area which required review was ensuring a lock was available on the door of the down stairs toilet to ensure residents' privacy and dignity was respected.

Residents' healthcare needs were assessed and plans of care were put in place to ensure these needs were monitored. Residents had access to comprehensive multidisciplinary supports such as behaviour therapy, psychology, specialist mental health services and general practitioner (GP) services. Staff ensured that where any specialist advice from speech and language therapy services was recommenced this was enacted. Assessments and personal plans were reviewed at four-monthly intervals and an annual review which included multidisciplinary staff and families also occurred. Staff had travelled to a meeting near one of the resident's parents' home to facilitate their attendance. A meeting between staff and the residents occurred weekly. Minutes were available of these meetings. Items discussed included going on holidays, celebrations for example birthdays, day to day running of the service for example menus, and activities. Residents had a takeaway on Friday nights. Plans were in place for residents who did not go home when the day services was closed for the summer break for residents to go on holiday and to the Zoo. Staff spoke about how they try to develop and sustain independent skills of residents for example, doing their own washing, helping look after the flowers and doing general household chores for example loading the dish washer. There was good communication between the centre and day services and the person in charge ensured that where residents' assessed needs changed for example with regard to nutritional care that the updated care plans were sent to day services. This ensured that day service staff were following the most recent recommendations of the speech and language therapy services, thereby protecting residents. Medication was managed by the residential services and no residents was prescribed medication while they were attending day services. Health and communication passports were also available in day services which meant if residents become unwell at day services staff have the required knowledge and information to accompany the

residents to acute medical services.

Regulation 12: Personal possessions

A financial assessment form was in place for all residents, however these were poorly completed in three assessment forms that the inspector reviewed. The decision making process as to how staff decided that residents were not capable of having full control over their finances was not clear as the rationale for the decision made was not documented and the completion of the form did not assist with understanding this either. The person in charge told the inspector, and there was evidence of this in documentation reviewed, and from speaking with residents that all residents could access their money as they wished by asking staff. All residents had personal bank accounts and bank cards. Each resident had a suitable place to store their belongings and clothing. Staff enabled and supported residents to complete their own laundry as part of building independence skills. Residents' clothing looked well cared for and residents' linen was in good condition and well laundered.

Judgment: Substantially compliant

Regulation 17: Premises

The provider ensured that the premises provided was of sound construction, in a good state of repair and met with the aims and objectives of the service.

The ceiling in the living room required painting, the toilet on the ground floor had no lock and the tarmac to the front drive required replacing or repair.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

Temporary absence, transition and discharge in this centre generally relates to residents going home or going on holidays. The inspector noted from documentation reviewed on inspection that there good liaison in advance with families prior to residents going home. There was also evidence of good planning prior to residents going on holidays which was usually linked to personal goals. The person in charge explained to the inspector that if a resident was being admitted to acute medical services, their hospital passport which encompassed a communication passport, a copy of the residents' medical prescription, a copy of the residents' nutritional care guidelines clothes and items that are important to the resident for example their

mobile phone or IPad or comfort items or communication aids would accompany the resident. Staff of the centre would usually stay with the residents while they were in acute care. On return to the centre a discharge letter, details of any changes to medication, a copy of any assessments completed for example by an occupation therapist of speech and language therapist would accompany the residents and if this did not occur staff of the centre would request same.

Judgment: Compliant

Regulation 26: Risk management procedures

This regulation formed part of the review of the targeted safeguarding programme action plan. 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 in the centre. The provider planned to have all actions complete by 31 October 2023. At the time of this inspection, two actions had been completed and one action was in the process of completion.

The completed actions included:

- A quarterly review of incidents by the incident monitoring and oversight committee.
- Training in incident management had been undertaken by senior staff of the centre.

Completion of these actions had enhanced the governance and oversight of incident management and increased support and information to staff on risk management in the centre.

The action in the process of completion related to the risk management policy which had not been finalised.

On this inspection the inspector found that there were systems in place in the centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. Where there were specific risks to residents, for example diabetes, these were identified and a specific comprehensive risk management plan which mitigated this risk was put in place.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A comprehensive fire safety management system was in place which included arrangements to detect, contain and extinguish fires and to evacuate the centre.

Each resident had a personal emergency evacuation plan (PEEP) in place which outlined the arrangements to support them to evacuate. The house was equipped with fire safety measures which included a fire alarm, fire doors, signage, emergency lighting, and fire fighting equipment.

However one area that required improvement related to completion of fire drills to ensure the continual safety and protection of residents. While fire drills were occurring at suitable intervals, fire drill records did not adequately outline whether the PEEPS were used and if they were effective. Simulated fire drills were not occurring when there was the least amount of staff on duty. This meant that it was difficult to review the effectiveness of the evacuation and make improvements if required.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment of need and a personal plan was in place which reflected their needs and was reviewed annually.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a range of allied health care professionals, to include GP, psychiatry, physiotherapist and specialist occupational therapy. This meant that their health care needs were monitored and appropriate supports were in place to support the residents' assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

This regulation formed part of the review of the targeted safeguarding inspection programme.

In response to this review the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements in this area. The provider aimed to have all actions complete by 30 June 2024. At the time of the inspection, six actions had been completed and one was in progress.

The completed actions included:

- An interim head of clinical and community support had been appointed
- Access to appropriate multi-disciplinary supports were in place
- The behaviour oversight committee was re-established
- The policy on the role of psychology and interdisciplinary team working had been developed.
- A review of accident and incidents had been completed by personnel independent of the centre
- Senior staff had completed training in incident management

Completion of actions in this area had improved services to residents who required behaviour support input as there was greater oversight of incidents and greater access to multi-disciplinary services. All staff were trained in positive behaviour support.

A review of the resident's placement had been undertaken. This is required to ensure each resident is appropriately placed and the voice of the resident with regard to their satisfaction of the placement is reviewed. While one resident was happy living in the centre, they were younger than other residents and some discussions had taken place as to whether they would be more compatible within another service or an individualised service. The resident had access to advocacy services and attended a younger profile day service.

The following action in progress was related to neurodiversity training:

The person in charge had completed neurodiversity training and was complimentary of the knowledge they had gained from this training. The provider had run this training as a pilot with all senior staff and had reviewed the content training based on feedback from senior staff. No dates were available as to when all other staff were going to attend this training:

On this inspection, the inspector found that the provider and person in charge had ensured that positive behavioural support plans were enacted to support residents with behaviours of concern. The inspector reviewed a positive behaviour support plan and found that it was detailed and clearly outlined proactive and reactive strategies that were person centred to support residents. There was very good input from multi disciplinary services. One restrictive practice was in place. This related to an alarm on the front door which alerted staff if a resident left the centre. This had been sanctioned by the human rights committee.

Judgment: Substantially compliant

Regulation 8: Protection

This regulation formed part of the review of the targeted safeguarding inspection

programme.

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 in this area. The provider aimed to have all actions complete by 31 October 2023. At the time of this inspection four actions were complete.

The completed actions included:

- A new system was in place to improve staff awareness of the safeguarding process.
- The person in charge reported that safeguarding was discussed at all staff meetings and included in supervision sessions. Staff spoken with were knowledgeable on the steps which should be taken should a safeguarding incident arise. Evidence was available that all staff had read the safeguarding policy.
- A plan was in place that safeguarding plans would be reviewed on a quarterly basis.
- A safeguarding oversight committee had been established.

All staff had completed safeguarding training on HSEland, however two staff had not attended face to face in person training.

Information in an easy to read format was displayed in the centre to inform staff and residents of the details of the local designated safeguarding officer and their contact details. As a result of the completion of these actions, the inspector found that staff spoken with had good knowledge of safeguarding, they were aware of the procedures they needed to follow to ensure that residents were safe, and the processes to follow if they had any safeguarding concerns. Details of advocacy services were displayed in the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for St Francis Residential Service OSV-0001774

Inspection ID: MON-0043881

Date of inspection: 31/07/2024

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Person in Charge will update staff rota to accurately reflect the staff on duty in the centre, including the time the PIC is working in the centre. The PIC will ensure that Staff from other service is not included in the centre roster.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has restructured the Senior Management team to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management, and oversight. Under the remit of the HSE's Service Improvement Team the Models of Service sub-group has been merged as part of the Quality, Safety and Service Improvement workstream. The Provider has devised a schedule of unannounced visits to commence in mid-September 2024. The bi-annual thematic governance and quality improvement report was completed and circulated to the Senior Management Team on 12th August. 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. A fortnightly Huddle takes place with updates on actions from: CEO; QSSI, HR, Operations, Properties and Facilities, Finance and others as required. This is communicated across the organisation through a flyer document.	

The provider has submitted a business case to the commissioner of services to strengthen the current on-call arrangement. An Organisational On Call Arrangement to be implemented in Q4 2024. Currently stakeholder engagement is ongoing, implementation phase will commence as soon as stakeholder engagement has been completed.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: The Person in Charge will ensure that all financial assessments are reviewed and that the decision making process as to the outcome of the financial assessments is clear and the rationale for the decision made is documented.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The lock on bathroom door has been replaced by maintenance team on 23/08/2024. The Person in Charge highlighted painting works to be completed to maintenance team, a painter has been organized to complete works. 06/09/2024 The Provider will complete the works required to the surface of the driveway at front of centre. This has been outsourced and will be completed by 28/02/2025

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports. The training module on the revised incident management framework policy commenced on the 15/05/ 2024. The risk management policy and associated training module are in consultation stage with various stakeholders for organisational implementation. The Risk Management Framework will be presented to the QSSI workstream for stakeholder engagement. Following consultation, a draft framework and training module was presented to the Senior Management Team on 20/08/24. A codesign of the module and policy with the Senior Operations Team and Frontline Managers will be undertaken by the week of 30/09/24. The pilot project commenced on 31/07/24 which will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review. The audits will be presented to the PIC forum on 16/09/24.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Person in Charge will ensure that fire drills are completed when there is the least amount of staff on duty, in addition the PIC will review the effectiveness of the PEEPs at staff meeting to ensure their effectiveness .

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Person in Charge will nominate staff to attend Neurodiversity training. 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 and is being rolled out to all staff in the organisation 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 including the Chairperson of the Rights Review Committee. The Inter Clinical Team Working policy will be implemented once the Clinical Lead has commenced in their position	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The Person in Charge will nominate two staff members for face to face safeguarding training in the next training calendar.	

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	20/09/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	20/09/2024
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Substantially Compliant	Yellow	20/02/2025

	the aims and objectives of the service and the number and needs of residents.			
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	20/02/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2025
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	20/09/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and	Substantially Compliant	Yellow	20/09/2024

	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.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	13/12/2024
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	13/12/2024