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:	Abbey Residential Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Announced
Date of inspection:	31 May 2024
Centre ID:	OSV-0004108
Fieldwork ID:	MON-0034901

About the designated centre

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

Abbey Residential Services can provide a residential service to six adults with intellectual disabilities who have low to high support needs.. The centre is comprised of two houses, and is located in a residential neighbourhood of a medium sized town where public transport links are available. Residents are supported by staff members both during day and night time hours.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Friday 31 May 2024	08:15hrs to 17:00hrs	Mary McCann	Lead
Friday 31 May 2024	08:15hrs to 17:00hrs	Úna McDermott	Support

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 others in progress.

Additionally the provider had submitted an application to renew the registration of this centre and this announced inspection also assessed the suitability of this centre for renewal of registration. In preparation for the inspection the lead inspector contacted the person in charge in advance, to discuss preparing for the inspection and the arrangements that would best facilitate residents so that inspectors would meet with as many residents as possible to ensure their voice formed part of the inspection. In discussion with the person in charge it was decided that to ensure as many residents as possible were offered the opportunity of meeting inspectors, the inspection would commence early so residents had an opportunity to meet with inspectors prior to attending day services and on returning from day services.

Inspectors reviewed all information that HIQA had regarding this centre. This included previous inspection reports and notifications about certain events that had occurred in the centre that the provider and person charge must submit as part of the regulatory process. The provider submitted all information required to renew the registration of this service prior to the inspection.

This inspection was an announced inspection completed over one day one month in advance. As part of this announced inspection, HIQA survey questionnaires, entitled 'tell us what it is like to live in your home' were provided to residents to complete prior to the inspection. Six questionnaires were completed, five by residents and one by a family member. All were reviewed by inspectors who found that residents' feedback was positive regarding the service provided to them and confirmed that they were happy living in the centre, there was good communication between staff and families, and their health and social care needs were met to a high standard. All residents were happy with their bedrooms which inspectors noted were personalised

and reflected the wishes of the residents.

Inspectors held an introductory meeting with the person in charge and the area manager on arrival to the centre to discuss the format of the inspection and to give the person in charge an opportunity to update inspectors regarding any specific issues for consideration regarding meeting with residents and the schedule for the day. Inspectors also gave the person in charge an opportunity to clarify any questions they had regarding the inspection.

This centre comprised two houses. One house (House A) accommodates four residents and the other house (House B) two residents. The houses are located in the same area approximately 5 minutes walk apart. Following the introductory meeting in house A, one inspector stayed in house A and the other inspector went to house B. Inspectors walked around the premises with the person in charge and introduced themselves to all residents and explained the role of the Health Information and Quality Authority (HIQA). Inspectors engaged with all of the residents. Residents told inspectors that that the service met their individual needs to a high standard, they enjoyed a good quality of life and they felt safe and comfortable living in the centre. Residents were satisfied with the opportunities available to them to engage in social activities that interested them and the supports they received including support to attend local day services and other activities in the community. Residents were supported to visit relatives, go for coffee and go away on mini breaks. Residents told the inspectors they were very happy and contented living in the centre and it was much better than the house they previously lived in. Inspectors observed staff chatting with residents in a knowledgeable, caring, respectful way about the day services and general activities planned. for example going for coffee, taking a train journey and the plans for the day. One resident had a fitness pal to monitor their sleep and one staff was explaining to the resident the quality of their sleep pattern for the previous night and was able to compare the sleeping pattern over a period of time on the IPAD. Residents were observed to be engaging well with fellow residents. Inspectors observed warm and comfortable interactions between staff and residents. A person centred rights based approach was evident in the centre where the voice of the resident was listened to. Residents' rights to privacy dignity and autonomy was protected and promoted by staff. For example, one resident who had a specific interest in drama was supported to attend the entire local drama festival. Staff had supported this resident to purchase a tuxedo as was their preference for attending. Staff were observed to be respectful of residents' choices and wishes as they assisted them and actively listened to them as they prepared their packs for going to the day centre. One resident expressed their satisfaction by stating, staff are very good, they help me to do lots of things, I love living in this house. Another resident said the food is good and I like helping with the cooking, staff bring me to see my relative and another resident told the inspector I get to do the things I like. Residents stated that they did not want anything changed to the current service that was delivered to them.

From what inspectors observed, read and were told by residents, inspectors found that a good quality service was provided to residents and that this was a nice place to live. Staff spoken with had worked with most of the residents for many years and

had a great knowledge of their likes, dislikes and planned goals.

In summary, from what residents told inspectors and what inspectors observed, coupled with reviewing documentation, inspectors were assured that that residents' rights were upheld, their voice was listened to and they enjoyed a good quality of life and were supported to stay in regular contact with their family and had access to meaningful activities. They were supported by a 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

Overall this inspection found that the service was well managed and provided a good service to residents. However, areas that required review included; ensuring the staff roster accurately reflected staff on duty day and night, a review of audits to ensure the service provided was effectively monitored. For example where an audit detailed that the medical consent should be reviewed annually but this was not occurring, no action plan was put in place to address this.

The provider's arrangements for monitoring the centre included six monthly unannounced visits. These were completed by staff independent of the centre. The most recent visit had been completed in May but no report was available at the time of inspection. The one previous to this had been completed in December 2023. An annual review for 2023 was completed and while a quality improvement plan had been completed post this review it was difficult to track completion of these actions as while timelines were in place, where timelines had expired there was no narrative to support what actions had been taken.

There were staff on duty in both houses in the morning time and in the afternoon and a sleep over staff was available in both houses. One resident had a 1:1 staff one day per week from 10.00 to 16:00 hrs. The staff rota in House A did not accurately reflect the staffing arrangements, for example a staff member was rostered to work from 07:30 to 16:00 hours but they were only in this centre from 7:30 to 10:00 am and then they attended other services to do individual work with designated residents four days per week as the residents in this centre were attending day services day. An on-call system was in place to support and guide staff out of hours should any emergencies arise.

The person in charge reported to a local area manager who was freely available on the phone to the person in charge and met regularly with them. The person in charge worked full-time and had responsibility for this centre and two other individual services. The person in charge was also supported by other persons in

charge in the local area. Adequate resources to ensure the effective delivery of a person centred safe service to residents were in place. Staff were visibly present in the centre and were seen have time to sit and chat with residents in an unhurried fashion.

Inspectors spoke with three staff members. Staff displayed a good knowledge of residents and could describe residents' likes and dislikes. Staff confirmed that they were provided with training to ensure that they had the skills and competencies to support residents with their assessed needs. Documentation reviewed supported that all staff had attended mandatory training and other training specific to the needs of the residents including first aid, epilepsy management, and minimal handling. Supervision occurred regularly and staff spoken with said that they felt well supported by the person in charge. Team meetings occurred regularly and minutes were available of these meetings so that staff who could not attend were aware of any discussions undertaken. An out of hours on call service was in place. This was under review by the senior management team and staff reported this was due to be finalised by the end of June. The current system in place was known by staff and details of this were on display in the centre.

An independent review of accident and incidents was completed on 26 January 2024. The person in charge told inspectors that the outcome of this was discussed with them and no actions were required post this review, however no documentation from this review was available to confirm the outcome of the review. A plan was is in place to re-audit these in May 2024.

While the statement of purpose contained all of the information as detailed in the regulations and gave a detailed outline of the service, facilities and care needs to be supported, it required review as the total staffing complement in full time equivalent numbers was not clear. An updated statement of purpose which is in compliance with the regulatory requirements has been submitted.

The provider had ensured that all schedule 5 policies and procedures were in place and available to staff. The risk management policy was in draft format. These policies supported and assisted staff in the delivery of evidence based practice and safe care.

Overall the findings of this inspection supported that this was a well-managed and well-run centre. Residents reported that were happy living in the centre. Residents were supported by a staff team who were familiar with their care and support needs.

Registration Regulation 5: Application for registration or renewal of registration

All of the required documentation to support the application to renew the registration of the designated centre has been submitted.

Judgment: Compliant

Regulation 14: Persons in charge

A person in charge who worked full-time and had the qualifications, skills and experience necessary for the duties was in post.

Judgment: Compliant

Regulation 15: Staffing

An established staff team was in place. Inspectors found that adequate staff were on duty to meet the needs of residents on the day of inspection. The staff rota was reviewed over a three week period and this was the usual staffing allocation. However, the staff rota in House A did not accurately reflect the staffing arrangements. For example, a staff member was rostered to work from 07:30 to 16:00 hours but they were only in this centre from 7:30 to 10:00am and then they attended other services as the residents in house A had gone to day services to do individual work with them four days per week.

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. All mandatory training was up to date. In addition, all staff had completed training in safe administration of medication and first aid. Staff supervision was occurring at quarterly intervals.

Judgment: Compliant

Regulation 22: Insurance

The provider had a valid 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 eight 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 had been completed
- The development of a service improvement team
- Unannounced provider visits by personnel independent of the centre
- Quarterly incident reviews through the incident monitoring and oversight committee,
- Regular regulatory training events
- The re-establishment of a human rights committee.
- A new one day induction training for new staff was developed and was in practice.

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.
- The implementation of the staff training and development plan
- A review of the current suite of audits was in process of completion
- The development of a standardised monthly reporting template

On this inspection inspectors found that the provider had ensured that there was a defined management structure in place with clear lines of authority and accountability. The centre was adequately resourced to ensure the effective delivery of care and support to residents. While the person in charge had only been in post for a few months they had plans in place for improvements in the centre. For example; a review of restrictive practices had commenced and funding for the redevelopment of the garden to make it safer at House A had been sanctioned. However, audit arrangements required improvements to ensure their effectiveness and to support quality improvement, for example inspectors found that the recording of the progression of personal goals was not occurring at four monthly intervals as per the provider's time line. In addition, assessments of need were not reviewed annually but no auditing was occurring of these processes. While audits were being completed by the person in charge to monitor the service provided, the quality improvement plans post these audits were not robust and required further input to ensure the deficits identified were addressed in a timely manner and a re-

audit occurred to assess for sustainable improvement. For example, where an audit detailed that the medical consent should be reviewed annually but this was not occurring, no action plan was put in place to address this

The provider had arrangements in place to complete six monthly unannounced visits. These were completed by staff independent of the centre. The most recent had been completed in May but no report was available of this at the time of inspection. The one previous to this had been completed in December 2023. An annual review for 2023 was completed and while a quality improvement plan had been completed post this review it was difficult to track completion of these actions as while timelines were in place, where timelines had expired there was no narrative to support what actions had been taken.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose which gave a detailed outline of the service, facilities and care needs to be supported and the total staffing complement in full time equivalent numbers was submitted post the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents as required to be notified to the Chief Inspector had been submitted

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

At the time of inspection a full time person in charge with the required qualifications and experience was in post since October 2023. This centre has not reported any absences of persons in charge to date.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

This centre has not had any occasion when it was required to submit a notification of procedures and arrangements for periods when the person in charge was absent.

Judgment: Compliant

Regulation 4: Written policies and procedures

Written policies and procedures were prepared in writing and available in the centre. A sample of these policies were reviewed and inspectors found had been reviewed in the previous three years.

Judgment: Compliant

Quality and safety

Overall inspectors found that residents enjoyed a good quality of life and a good service was provided to residents. Residents' healthcare needs were assessed and plans of care were put in place to ensure these needs were monitored and any health issues that were identified, plans were developed to manage these needs. Individual assessments and personal plans were developed, however improvements were required to tracking of residents' goals in House A, and in house B while individual assessments and personal plans were in place improvements were required to ensure these plans were reviewed annually. Residents had access to multi-disciplinary supports such as behaviour therapy, psychology and a general practitioner services.

There had been substantial improvements to the premises of both these houses since the last inspection in 2022 and residents told inspectors that they enjoyed living in these premises much better now than previously available to them. The centre comprised of two houses which were laid out to meet the needs of residents and provided a comfortable home to residents. The houses were decorated to a good standard internally and were homely, comfortable, clean and pleasant. House A is a bungalow style dwelling with 5 bedrooms, 4 residents' bedrooms and one staff bedroom. Each resident had their own personalised bedroom, two of which had ensuite facilities and the other two bedrooms had a large shared accessible shower room which was located in close proximity to their bedrooms. This assisted to maintain the privacy and dignity of residents as they required to use the communal corridor for a short distance and was located at the end of the corridor away from the front door. A well sized sitting room with good light and comfortable furniture was located to the front of the house with a kitchen cum dining room and a utility room. There were patio doors off the kitchen at the back of the house where a patio

was available to residents. Residents were observed on the afternoon of the inspection to be sitting with staff chatting in the patio area. A visitor's room was located in close proximity to the front door. There was a parking area and garden to the front of the house and a garden to the back of the house. Improvements were required to the garden area to the back of the house as it was not safe for residents to use independently due to the steep slope. The person charge informed inspectors that funding was available to re-design the back and front gardens. It was also planned to paint the external of this house once the garden was completed.

House B is two storey semi- detached house. Some areas of this house were refurbished recently. Improvements had been made to the kitchen, and the centre had been painted and decorated internally. The house was clean, tidy and well furnished. Residents had their own bedrooms which were personalised and shared a bathroom. The sitting room provided a pleasant area to relax and watch television or listen to music. While the internal of this house provided a pleasant comfortable place for residents to live and relax in, improvements were required to the external areas to ensure it provided a suitable area for residents to enjoy. Areas that particularly required review included the windows, gutters and the external paint work. Also the garden fence was broken.

There was good communication between the centre and day services. A medical folder where required accompanied residents to and from day services. This included speech and language therapy guidelines regarding nutritional intake, medication prescription chart and health and communication passports. This means that residents receive their nutritional care in a safe way and that if residents become unwell at day services staff have the required knowledge to accompany the residents to acute medical services. Also residents' day medication is administered from their original prescription which is in keeping with best practice.

Regulation 17: Premises

Improvements were required to the external areas to ensure it provided a suitable area for residents to enjoy in House B. Areas that particularly required review included the windows, gutters and the external paint work. Also the garden fence was broken. Plans were in place to complete this work.

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 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.

Actions completed 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 inspectors 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 weight loss, 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

The provider had fire safety management systems in place including arrangements to detect, contain and extinguish fires and to evacuate the premises. There was access to three exits in House A and two in House B. Quarterly certification of emergency lighting was in place. Fire extinguishers was serviced annually. All staff had training in fire safety. Personal emergency evacuation plans was in place and staff spoken with confirmed that they was confident they would be able to safely evacuate at any time if required to do so and the fire safety plan would be enacted to assist with the safe evacuation of the residents. Records of fire drills including simulating night time drills was available for review. The fire drill template enabled a review post the drills to evaluate their effectiveness.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

All residents had an assessment of need and a personal plan was developed which reflected these needs. However not all had been reviewed annually. Personal goals

were identified but progression of these goals was not clearly documented. In house A there was poor evidence of the progression of goals and there were gaps in progress notes about residents' personal goal whereby progress was not reviewed every four months as set out in the timelines set by the provider. For example; one resident had requested a television for their bedroom in early 2024 and from a review of the documentation it seemed that this goal had not been progressed. However on speaking with the person in charge it was clear that a lot of work had been completed on this goal and the TV had been chosen by the resident and purchased but the centre was awaiting the electrician to come and install of the TV. While the person in charge could verbally tell the inspectors of the progression of the goals, no auditing was occurring with regard to the completion of personal goals

Judgment: Substantially compliant

Regulation 6: Health care

The health needs of residents were well managed. Good person centred health assessments was completed for example nutritional care and arthritis care. Records of attendance at allied health professionals and the general practitioner was recorded and the rationale for same was well documented. However, the area manager or person in charge could not confirm that residents were facilitated and supported to avail of health screening programmes appropriate to their age, for example breast screening or bowel screening.

Judgment: Substantially 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, 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

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.

The following actions had not been completed;

- The person in charge had completed neurodiversity training and told inspectors that senior staff were attending this training as part of a pilot programme, and when the pilot was completed training would be offered to all staff. However, no dates were available for other staff to attend this training.
- There was no evidence of a review of the placement of the residents. 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.

On this inspection inspectors found that the provider and person in charge had ensured that positive behavioural support plans were enacted to support residents with behaviours of concern. A sample of positive behaviour support plans were reviewed. Inspectors found that these were detailed and clearly outlined proactive and reactive strategies that were person centred to support each resident. Restrictive practices which were in place in the centre were sanctioned by the Human rights committee. The person in charge told the inspectors that the restrictive practices that were reported in the most recent notifications had been reviewed the day prior to the inspection and less restrictive options were to be piloted. This was supported by reviewing the team meeting minutes. The kitchen was not to be locked post meal times when the hob of the cooker was hot as staff were always present in the kitchen to supervise residents. Magnets were to be fitted to kitchen cupboards as opposed to locking them for the safety of some residents. This meant that residents who could safely access cupboards could do so.

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 all 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. Evidence was available that all staff had read the safeguarding policy. All staff had completed safeguarding training on HSEland and all staff had attended face to face in person training. A plan was in place that safeguarding plans would be reviewed on a quarterly basis. A safeguarding oversight committee had been established. Staff spoken with were knowledgeable on the steps that should be taken should a safeguarding incident arise.

Visual information was displayed in the centre to inform staff of the details of the local designated safeguarding officer and their contact details. As a result of the completion of these actions inspectors found that staff spoken with had good knowledge of safeguarding, and 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. The contact details were accessible of the local safeguarding officer. Details of advocacy services were displayed in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that respected the rights of residents. Residents' meetings were held weekly. Residents chose their meals and activities were discussed at these meetings.

Residents' bedrooms were personalised and residents proudly showed their bedrooms to inspectors. Residents’ voices were listened to and their consent was sought about their care and welfare. Residents told inspectors that they were involved in the day to day operation of the service and they enjoyed living in the centre. Advocacy services were available to residents.

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	
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
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Abbey Residential Services OSV-0004108

Inspection ID: MON-0034901

Date of inspection: 31/05/2024

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Roster has been reviewed and now reflects the hours being worked in designated centre.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Person in Charge is reviewing personal goals and updates are completed as per the providers policy. The Person in Charge has reviewed the 'Assessments of need' for each resident, the PIC will ensure this assessment is reviewed annually. The Person in Charge will ensure quality improvement plans are in place for audit actions identified. The six-monthly unannounced report is available to view in the service, the PIC has a timebound quality improvement plan agreed to address actions. The Provider has restructured the Senior Management team to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management, and oversight. Under the remit of the HSE's Service Improvement Team the Models of Service sub-group has been merged as part of the Quality, Safety and Service Improvement workstream. The Provider has revised the unannounced visit template and unannounced visits are scheduled up to 31/7/2024. The next bi-annual thematic governance and quality improvement report will be presented to the Board at the end of July. A learning management system pilot has commenced in two service areas for staff	

training and development and aims to implement the system to the rest of the organisation by the end of the year. The provider continues to facilitate monthly staff regulatory events. The quarterly properties and facilities plan is presented at senior management for oversight with regard to its monitoring and implementation.

An organisational report is submitted to the provider from the senior management team through the Chief Executive Officer every 2 months. 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 interim arrangement for on call is in place across a number of service areas and some discussions are ongoing in one area. In addition, the provider is working to provide an interim on call arrangement across all Areas and Departments.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Person in Charge has a timebound plan to address the home improvements required in both house A and house B. This will include garden upgrades, window cleaning and gutter maintenance along with external painting.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports.

The training module on the revised incident management framework policy commenced on the 15/05/ 2024. The risk management policy and associated training module are in consultation stage with various stakeholders for organisational implementation. The Risk Management Framework will be presented to the QSSI workstream for stakeholder engagement. Following consultation, a draft framework and training module will be presented to the Senior Management Team which will include stakeholder feedback on the 23/07/2024.

The pilot project is commencing on 31/07/24 which will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual

assessment and personal plan:
The Person in Charge will undertake a comprehensive audit of all personal plans in the area of goal progression, a quality improvement plan will be devised in collaboration with each resident's 'Name Staff'.

The Person in Charge will audit individual planning folders as per the providers policy each quarter.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Peron in Charge has reviewed each resident's 'Heath Action Plan' and each resident is availing of health screening programmes appropriate to their age.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Each resident is supported in the 'Circle of support' forum to review their living options and escalate any dissatisfaction. Along with this forum the 'Annual Review' of the service ensures the voice of the resident is considered. The Person in Charge will lead this process on an annual basis or as required.

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 on the week commencing 15/07/24 prior to implementation. The Inter Clinical Team Working policy will be implemented once the Clinical Lead has commenced in their position.

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 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	23/07/2024
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	14/02/2025
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'	Substantially Compliant	Yellow	30/08/2024

	needs, consistent and effectively monitored.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	30/08/2024
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	21/10/2024
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	21/10/2024
Regulation 06(2)(c)	The person in charge shall ensure that the resident's right to refuse medical treatment shall be respected. Such	Substantially Compliant	Yellow	23/07/2024

	refusal shall be documented and the matter brought to the attention of the resident's medical practitioner.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/09/2024