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:	The Acres Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Short Notice Announced
Date of inspection:	19 August 2024
Centre ID:	OSV-0004810
Fieldwork ID:	MON-0041329

About the designated centre

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

The Acres can provide residential support support to three people over 18 year of age until end of life; both male and female; with autism and intellectual disability who may present with associated complex needs such as medical, physical and or sensory disability. The centre comprises of two houses located in close proximity to each other, one is divided into two self contained apartments and the other house is a fully accessible bungalow which accommodates one resident. The centre is located within walking distance of a rural town where a wide range of facilities are available. Transport is available for community activities. Residents are supported by a staff team of social care workers and healthcare assistants. Sleepover staff is available in both houses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 19 August 2024	10:00hrs to 16:45hrs	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 management. An update on each of the areas focused on as part of the targeting programme is contained in this report.

This was an unannounced inspection carried out as part of the Chief Inspector's regulatory monitoring of the centre. The Acres residential services is registered to provide residential care to three residents. There were three residents living in the centre at the time of this inspection and the inspector met all three residents. The centre comprises of two houses, located approximately 2 kilometres apart. Both houses are located in a residential area of a rural town. House A is a detached bungalow style house, which provides individual services to two residents in two separate apartments. The only aspect of this service that is shared is the utility room, located in apartment 1, where a tumble dryer and washing machine was shared. The person in charge told the inspector that there is a plan to develop an external shed into a utility room for apartment 2 to ensure both residents have a completely independent service. House B is located approximately 2 kms away provides an individual service to one resident. Both houses provide a comfortable home to residents. The location of the centre enables residents to visit the shops, cafes and other leisure amenities in the area. Each resident had individual transport, which could be used for outings or any activities that residents chose. Staffing levels in the centre ensured that each resident was supported by staff to do activities of their preference. Both houses had a garden where residents could spend time outdoors. Garden furniture was available. However in house A, there were aspects of the garden that required review to ensure residents could access it safely. This is discussed under regulation 17 further on in this report. A bespoke trampoline was available in the back garden of house A. During a walk around both houses the inspector found that they were nicely decorated and personal items were available

to create a more homely atmosphere for residents. In House A, apartment 1, some windows had condensation issues. Furniture and fittings were appropriate to the needs of residents and were in a good state of repair. In house A, apartment 1, there was a purpose built bench seat in the kitchen and the resident had a bespoke rocking chair. Staff knew residents' likes and dislikes and residents enjoyed a good quality of life. Residents who were able to converse with the inspector were complimentary of the services provided or made gestures as to their satisfaction with the service provided. Staff were observed to be attentive and kind to residents and spoke warmly about residents and how they enjoyed working with them and the activities residents enjoyed. For example; looking in the fields at farm animals, walking in the forest, going to the spa and getting their nails done. Residents attended various local events in the town and staff spoke about how well engaged they were in the community and that lots of local people knew the residents and acknowledged them as they used the town's local amenities and walked to the shops. There was good evidence of regular contact with residents' families and one resident had shared care with their family and went home regularly. The inspector observed that residents were comfortable and relaxed in the company of staff which added to a pleasant homely atmosphere. Some staff had known residents and their families for many years. Staff had undertaken training in human rights and were very aware of the importance of ensuring care was provided according to the choice and consent of the resident. All residents had an individual service which was tailored to the wishes of the resident. Residents' right to autonomy was supported where staff spoke about choice and consent of residents and ensuring the residents' skills to do tasks independently, for example making their lunch, was supported. One resident recently had a birthday and this was celebrated in the centre. The inspector spoke to the resident about the way their birthday was celebrated and they seemed delighted and was smiling and happy having the discussion.

In summary, from engagement with the three residents living in the centre at the time of this inspection, observations of staff interacting with residents during the inspection, meeting with the person in charge and three staff and reviewing information, the inspector found that residents were well cared for and the inspector was assured that residents enjoyed a good quality of life and had access to meaningful activities. Care was person-centred and the voice of the residents was considered in planning care and activities. The consistency, knowledge and levels of staff team enhanced the lives of residents.

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 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 who was organised and displayed a very good knowledge of the service and the residents. She was supported in the day to day management of the centre by an assistant manager . The person in charge was responsible for this centre, another sister service which was located in close proximity to this centre. When the person in charge was not available there were clear structures in place to support staff which included an assistant manager, 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 comfortable environments, adequate staffing levels to support residents in both their leisure and healthcare needs, and a transport vehicle for each resident. The person in charge had supervision with her line manager at quarterly intervals. Regular management meetings, including person in charge forums which met quarterly, were occurring which the person in charge attended. The person in charge stated she found these meetings very valuable as they were a great forum to share knowledge and discuss any issues of concern and updates to policies and practices. The agenda for the centre staff meeting was similar to both these meetings.

The provider has submitted a compliance plan in response to the findings of a provider-wide targeted inspection programme in March 2023 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. 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. 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. 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, and

which focused on the safety and quality of care and support provided in the centre. The most recent one was dated 01/05/2024. A plan was put in place to address any areas to be addressed post this review. All actions had been completed to include updating personal evacuation plans, ensuring team meeting agenda included risk management discussion and quality improvement plans. 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 was completed on the 15/05/2024. While this was a comprehensive review it did not include consultation with residents.

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 residents receive 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 as the person in charge's hours in the centre were not recorded.

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 not all mandatory training was up to date, this is detailed under regulations 7 and 8. Staff had completed additional training to ensure they had the required competencies to ensure the delivery of safe quality care to residents. This included training on safe management of medication, safe management of epilepsy and first aid training. In addition, all staff had completed training in human rights. Staff spoken with stated that this had influenced their practice and they were more aware of the importance of the views of residents and these were taken into consideration.

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 centre. The person in charge was complimentary of the changes in governance since the commencement of the enactment of the actions from the targeted programme. They stated there was better communication because of learning events and minutes of meetings they regularly receive. They felt there was better support from behaviour support services and for incident management.

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. Management systems were in place to ensure that the service provided was appropriate to the needs of residents and effectively monitored. The centre was adequately resourced to ensure the effective delivery of care and support to residents. Regular audits were being completed by the person in charge. Audits undertaken included health and safety, finances, medication and fire safety. Six monthly unannounced visits and annual reviews were being completed and where issues were identified for review these had been actioned.

While a comprehensive annual review had been completed this did not include consultation with residents. An easy to read copy to ensure accessibility for residents was not available.

Judgment: Substantially 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 ensure that appropriate fire safety procedures were in place to protect residents and staff. A door on entry to the utility room in House B where a washing machine and a tumble dryer was in place, was not a fire compliant door. The provider has provided written assurances to the authority that a fire door has been installed in this area.

The residents' health, social and personal needs had been identified and assessed. The necessary supports to meet the assessed needs of residents was in place and staff were knowledgeable on how to support residents. Residents were supported to access services and appointments with healthcare professionals. Assessments and personal plans were reviewed at four-monthly intervals and an annual review which included multidisciplinary staff and families also occurred. A range of healthcare professionals, including speech and language therapy, physiotherapy, and behaviour support staff were available to support residents as required. Residents were offered choices and these choices were respected. Residents' interests and preferences had been identified and residents were supported to pursue those interests in the centre and the wider community. The safety of residents was promoted. Risk assessments had been devised to ensure that staff knew how to reduce risks to residents. Staff were knowledgeable on safeguarding procedures. There were no active safeguarding plans in place at the time of this inspection. Some restrictive practices had been introduced in the centre to keep residents safe and at the request of residents. These were regularly reviewed and included on the centre's risk register. 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 and whether the personal emergency evacuation plans (PEEPs) were effective or required review.

Regulation 12: Personal possessions

A financial assessment form was in place for all residents, however these were

poorly completed in the two assessment forms reviewed by the inspector. 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. 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

Both houses were located in residential areas, close to a town, which gave residents good access to a wide range of facilities and amenities including shops, cafés and walking areas. The centre was clean and tidy. Each resident had their own bedroom and there was adequate shower and toilet facilities. However in house A, there were aspects of the garden that required review to ensure residents could access it safely. There was condensation on some of the windows in apartment 1 in house A. Additionally the footpath around the house was uneven in places.

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 was 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 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

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. 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 learning takes place through the quarterly incident data reports.

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 epilepsy or issues with impaired swallowing, these were identified and a specific comprehensive risk management plan was 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. Fire drills were occurring regularly and supported that good fire safety procedures were in place at the time of this inspection. As discussed previously in the report, a fire door required installation in House B and written assurance has been provided to the authority that this has been completed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs were regularly assessed and care plans were developed based on residents' assessed needs. The plans of care viewed during the inspection were up to date and were reviewed annually. Personal goals were identified and these were actioned, for example one resident wished to go on an aeroplane and this had been organised and completed. The resident smiled broadly when spoken with regarding this.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a range of allied health care professionals, to include GP, psychiatry, physiotherapist and occupational therapy. The residents were supported and informed about their rights to access health screening programmes and vaccination programmes available to them. Residents were supported to attend medical and healthcare appointments as required.

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:

- 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
- A review of the residents' placement had been undertaken.

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.

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. All staff had been nominated to attend this training but had not received this training at the time of inspection.

On this inspection, the inspector found that the provider and person in charge had ensured that positive behavioural support plans were in place for all residents who required same. The inspector reviewed two positive behaviour support plans and found that these were detailed and clearly outlined proactive and reactive strategies that were person-centred to support the residents. There was good evidence of input from multi-disciplinary services. While there were some restrictive practices in place there was good evidence that staff were trialling less restrictive options. All restrictions in place had been sanctioned by the human rights committee. Not all staff had completed behaviour support training.

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.

In the compliance plan submitted by the provider they had committed that in addition to the HSE online safeguarding training, all staff would attend a safeguarding training module through face to face learning events by trained designated officers employed by the provider.On this inspection the inspector found that the provider had ensured that all staff had completed safeguarding training on HSEland. However the person in charge informed the inspector that two staff had not attended face-to-face in person training in safeguarding at the time of this inspection. 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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially 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	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 The Acres Residential Service OSV-0004810

Inspection ID: MON-0041329

Date of inspection: 19/08/2024

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: PIC has recorded on the planned 3 week rolling roster template, details of their contracted hours per week, assistant managers contracted hours per week and their responsibility across two designated centres. Complete A blank roster template has been introduced in the service where the PIC and the Assistant Manager now record when they are on site in the designated centre. Complete The Statement of Purpose has been updated to include the roster change. Completion date: 07/10/2024.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: PIC will ensure that the annual review will include consultation with person supported using communication tools that are specific and meaningful to them – this will include but is not limited to; easy read guides, visuals and social stories. Completion Date: 31/05/2025 The providers on call review is currently in progress. Completion Date: 31/01/2025 The providers current onsite audits review is also currently in progress. Completion Date: 31/01/2025	

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The providers current financial self-assessment tool does not support holding the information for why a person may choose to not take control of their own finances. The provider will review the current template in place to incorporate the rationale as to how a decision is made for a person supported to take control or not take control of their own finances. Completion Date: 31/03/2025

In the interim, the PIC has customised the current financial self assessment in the service to include this information. Completed

As evidenced during inspection, this is recorded on the service Restrictive Practice log, which has been reviewed by the Rights Review Committee and is returned on a Quarterly basis to HIQA via the portal.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As evidenced during the inspection, the works to the garden to the rear of the property were underway. Work completed 04/09/2024.

A plan has been developed in collaboration with the facilities department to address repairs required to the footpaths at the front and to the side of the property. This work is weather dependent as it requires the pouring of concrete, therefore an extended completion date of 30/04/2025 has been assigned. Weather permitting, this date will be brought forward.

The maintenance team have reviewed the windows where condensation was noted, in collaboration with facilities a plan has been developed to replace the window. Part of this plan is that the PIC of the service will make contact with the landlord of the property to determine their willingness to contribute to the cost of same. Completion date: 30/11/2024.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports.
The 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 has been 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 31/10/2024.

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 were presented to the PIC forum on 16/09/24. The medication and staff file audit will be completed on the Viclarity system for quarter 3 2024.

As evidenced during inspection, all Risk Assessments present in the service are updated on a 6 monthly basis or more frequently as required. In the event of an emergency or incident in the service, relevant Risk Assessments are reviewed as a result.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
There are two staff within the team that require Managing Behaviours of Concern training. As an interim measure and as evidenced during inspection, these staff have received bespoke training in Managing Behaviours of Concern due to changing needs in the service. They will attend the three day course as soon as a space becomes available but no later than 31/03/2025. Rostering has been reviewed to ensure correct skills mix where there is no lone working with this individual by these two staff. Completed

The service Statement of Purpose will be updated to include Managing Behaviours of Concern as a mandatory event for the service instead of discretionary. Completion Date: 07/10/2024.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The national requirement for training in safeguarding is for all staff to complete the HSEland training module.
As evidenced during inspection, all staff have completed the Safeguarding training module on HSEland. Completed.

The service Statement of Purpose will be updated to reflect completion of the Safeguarding training on HSEland is the providers requirement. Completion Date: 07/10/2024.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	31/03/2025
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	07/10/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	30/04/2025

	kept in a good state of repair externally and internally.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/05/2025
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	31/01/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	04/10/2024
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging	Substantially Compliant	Yellow	31/03/2025

	including de-escalation and intervention techniques.			
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	07/10/2024