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:	Aras Aoibhinn Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	05 September 2024
Centre ID:	OSV-0001751
Fieldwork ID:	MON-0043060

About the designated centre

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

Aras Aoibhinn Residential Services is a designated centre operated by Western Care Association. The centre can provide residential care for up to four male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of one bungalow located on the outskirts of a town in Co. Mayo. Within the house residents have their own bedroom, some en-suite facilities, spacious bathrooms and shared access to a kitchen and dining area, sitting room and utility.The house also includes a staff sleepover room and office. A side and rear garden area is available to residents, to include, a sensory garden, where residents can sit and relax in, as they wish. Staff are on duty both day and night to support the residents who live in this centre.

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
Thursday 5 September 2024	11:40hrs to 18:50hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was completed to monitor compliance with the regulations and to inform the renewal of the registration of the centre. Overall, this inspection found that the service provided in Aras Aoibhinn was person-centred and was suitable to meet the needs of residents.

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 which took place over two weeks in March 2023 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection), regulation 23 (Governance and management) and regulation 26 (risk management procedures). The overview report of this review has been published on the HIQA website. In response to the findings of this review, Western Care Association submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, but also to assess whether the actions of Western Care Association have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Mayo. At the time of this inspection a number of actions had been implemented, with others nearing completion. The management team met with on this inspection, spoke positively about changes that were implemented, particularly in relation to the management on-call system. Other actions completed and improvements noted will be discussed under each regulation later in the report.

The centre provided residential care to three residents at the time of inspection. There was one vacancy which occurred following the death of a resident in December 2021. The inspector was informed that reviews were occurring to seek a compatible person to move in. The existing residents had been referred to an advocacy service to support them with consultation about a new housemate. This demonstrated a person-centred and human rights based approach to care.

On arrival to the centre on the morning of the inspection, the inspector met with a member of the local management team who was in the position of 'team leader'. They reported that they had recently been appointed and had only worked in the centre for a few weeks. They were available throughout the inspection. The inspector gave them a document called 'nice to meet you' that inspectors use to support residents to understand the purpose of the visit. The person in charge arrived to the centre shortly afterwards and they were available throughout the inspection.

All three residents were out of the house when the inspector arrived. Two residents returned later in the morning having been out with their support staff for an

individual activity. One resident who attended an external day service each day was met with on their return home in the evening. The inspector spent time with all residents. Residents required various supports from staff in communicating. Staff were observed to be knowledgeable about residents' needs and about how to best support them. Staff supporting residents assisted them to communicate with the inspector and also spoke about what life was like for residents living in the centre. Residents appeared at ease and relaxed in their home and with each other.

One resident attended a day service each weekday. Two residents chose to remain at home and do activities from there. There were two staff in place during the day to support residents to do individual activities. There was also two staff each evening who did sleepovers each night. The centre had a vehicle to bring residents to activities in the community. Throughout the inspection residents were supported to go for walks, attend sensory spaces in external locations and to go swimming. Within the house residents were observed relaxing in their preferred areas of the communal rooms and engaging in activities such as watching programmes on a technological device. Observations were that the residents were supported in a kind and respectful manner by staff. Residents appeared comfortable with staff. Staff spoken with were knowledgeable about residents' individual needs and preferences.

The house was bright, homely and well maintained overall. Since the last inspection, new flooring and new doors had been installed. In addition, residents' bedrooms had been upgraded and were in progress for completion. This included new wardrobes in two residents' bedrooms. The colours and furnishings in the house created a warm and relaxing space. In addition, there was a beautiful sensory garden area created to the side of the house, which could be accessed through communal room. The communal rooms were designed around residents' needs and individual preferences, with areas of the rooms equipped with items of interest to individual residents. This included areas decorated with sensory items, music players and personal items of importance for individual residents. In addition, there were exercise equipment and comfortable furniture, such as a nest chair, which created a nice space for relaxation and leisure time.

From discussions with staff and a review of records, it was clear that residents' safety and wellbeing were promoted. Residents' care and support were kept under ongoing review and where changes occurred these were followed up to ensure appropriate supports were in place. For example; residents' mobility changes were followed up with the relevant members of the multidisciplinary team (MDT) to ensure that the most appropriate supports were provided.

The premise was designed to ensure maximum accessibility for residents. There were handrails at access points and throughout the house. Residents had their own individual furniture, aids and appliances for their individual needs. There was a large bathroom with a Jacuzzi bath, as well as level access showers. Laundry facilities were available in a separate utility area. This was clean and accessible to all.

Some staff had undertaken training in human rights. This was noted to be part of the central induction training for new staff. One recently inducted staff member said that they found all the training that they received useful. The inspector was

informed that the provider was currently reviewing its mandatory training modules for staff and it wasn't yet established if all staff were required to complete human rights training. Notwithstanding that, the centre promoted a human rights based approach. From discussion with the person in charge, it was clear that restrictive practices were kept under ongoing review with the aim to safely reducing them where appropriate. In addition, a review of residents' meetings had occurred to see if the meetings were meaningful for individual residents. Following this review, the inspector was informed that consultation with residents would occur through individual conversations on an ongoing basis, rather than group residents' meetings. It was explained that this type of consultation would be more meaningful for the individual needs of residents in this house. This showed that the management team strived to maximise residents' independence in making choices about their lives. It also showed that ongoing reviews of systems occurred to see if they were effective or not.

In addition, it was clear that the service sought to make information available to residents in an easy-to-read format. For example; there were posters throughout the house with information about advocacy, fire evacuation and a photographic staff roster. There was a folder of easy-to-read documents for residents available in the office. This included information on abuse, complaints, supports with money, advocacy and healthcare needs. Some of the documents in this folder had out-of-date information. This was updated on the day by the team leader. There were a range of policies and procedures and documents in place for supporting residents. However, it was not clear that residents were sufficiently supported in line with their assessed needs, with regard to the spending of their money. This will be elaborated on later in the report.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affects the quality and safety of the service provided.

Capacity and capability

This inspection found that the governance and management arrangements in the centre was good. There were systems in place to monitor the service on an ongoing basis. These systems were generally effective in identifying actions for quality improvement. However, some improvements were required in ensuring actions identified through provider audits were specific, measurable, achievable, realistic and timebound (SMART). This would mean that they could be tracked and addressed more effectively.

The governance and management arrangement in place included a team leader, a person in charge and an area manager. The team leader had recently commenced. This was a new post to strengthen to governance of the centre as the current person in charge was an 'area manager' and had other areas of responsibility

outside this centre. The team leader worked full-time and supported the person in charge with the operational management of the centre. There was an on-call arrangement for out-of-hours.

The centre appeared to be resourced effectively with a vehicle and with the numbers and skill mix of staff. Staff were supported through ongoing training and through regular supervision meetings. In addition, team meetings were held regularly. This provided opportunities for staff to come together and discuss and review incidents and practices.

Oversight and monitoring of the centre by the local management team was done through a suite of audits. The provider monitored the centre through unannounced visits every six months. This is a requirement in the regulations. Audits were generally effective in identifying actions for quality improvement. However, as noted above, some actions identified were not SMART. This created a risk that they would not be completed in a timely manner.

Overall, the centre was found to be well managed and monitored by the provider and the local management team.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted an application to the Chief Inspector to renew the registration of this centre within the time frame required. All the information that was required to be submitted as part of the registration renewal had been completed. Some minor amendments were required to some documents. These were completed on the day of inspection and submitted post- inspection.

Judgment: Compliant

Regulation 22: Insurance

The provider ensured that there was up-to-date insurance in place for the centre.

Judgment: Compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 12 actions aimed at improving governance arrangements at the centre. The provider aimed to have all actions

completed by 31/01/2024. At the time of the inspection nine actions had been completed with the remainder in progress.

The completed actions included the restructure and appointment of new senior management posts, a review of all the organisation's policies and procedures, the re-establishment of a human rights committee, quarterly incident reviews through the incident monitoring and oversight committee, regulatory training events for staff and unannounced provider audits completed by objective personnel on behalf of the provider.

In addition, the inspector was informed that a formal on-call arrangement had been agreed and was due to be commenced the following week. At the time of inspection, work was being done on devising a protocol and guidance for the 'on-call' system. The local management team felt that this system would be of great benefit to managers, as it allowed them time off from being 'on-call', where they had previously been on-call every weekend.

Some other actions in progress and not yet completed included:

- The full implementation of a staff training and development plan. The inspector was informed that a new online system for requesting training was in progress. The inspector was shown how this system worked for managers to monitor and have oversight of staff member's training needs and completion dates.
- The suite of audits for centres was under review. The inspector was informed that there was a new system developed for completing audits online. The local management team said that this would allow for reports to be generated for managers for individual centres, as well as organisation wide reports for the provider. This would include findings from provider's unannounced visits to designated centres. This, they felt, would be of great benefit to the management team and provider, as it would provide more accessible oversight.

Within this centre, there was a good management structure with clear lines of accountability. There were systems in place for reviewing and monitoring the centre. The monitoring arrangements by the local management team included regular auditing of; infection prevention and control (IPC), finances, personal plans, restrictive practices, medication, fire safety and health and safety.

The provider ensured that an annual review of the quality and safety of care provided in the service occurred which included consultation with residents and their representatives, as relevant. In addition, unannounced visits by the provider were completed as required in the regulations. However, one area that required review was as follows;

- to ensure that actions identified through provider audits are relevant, specific, achievable, clear on who is responsible for their completion and what the time frame for completion is.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider ensured that there was an up-to-date statement of purpose in place that included all of the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of incidents that occurred in the centre found that the person in charge had submitted all the notifications to the Chief Inspector as required under the regulations.

Judgment: Compliant

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

The provider ensured that the Chief Inspector was informed of the planned absence of the person in charge, within the time-frames required.

Judgment: Compliant

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

The provider ensured that the Chief Inspector was informed of the arrangements during the period of planned absence of the person in charge. This related to the area manager covering as person in charge for a period of time that the person in charge was on planned leave.

Judgment: Compliant

Regulation 34: Complaints procedure

There were no open complaints in the centre at the time of inspection. The provider had a complaints policy and procedure in place that provided guidance should anyone wish to make a complaint. This included details of the complaints officers and the time lines for responding to complaints. This also included information about how to appeal the outcome of complaints.

There was an easy-to-read version of the complaint procedures in a folder of accessible information for residents to aid with understanding. This required updating to amend some outdated information. This was completed on the day by the team leader.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had a range of policies and procedures in place to promote a safe and good quality service. These included all polices that are required under Schedule 5 of the regulations. These were accessible in the service and reviewed as part of the inspection.

Judgment: Compliant

Quality and safety

The service provided in Aras Aoibhinn was found to be safe and to a good quality overall. Residents' needs were assessed regularly. Systems in place promoted residents' safety and wellbeing. However, areas found to require improvements related to the supports given to residents in making decisions about how they spend their money, and in ensuring that residents' personal possessions are protected. This will be elaborated on under Regulation 12: personal possessions.

The inspector found that residents' needs were kept under ongoing review in the centre. Residents had access to MDT members as required to support with stress management and mobility needs for example. Care plans were in place to provide guidance in the supports that residents required with their assessed needs. These included; behaviour support plans, intimate care plans, communication plans and risk management plans. Care plans were kept under review and updated as required. Staff spoken with were familiar with residents' individual needs. Staff were observed supporting residents in line with the guidance in their care plans.

Residents' safety and welfare were promoted in the centre. There were policies and procedures in place for risk management, fire safety and protection against infection. The implementation of these polices ensured that the premises were safe,

clean and well maintained. In addition, individual risks affecting residents were assessed and kept under ongoing review. For example; risks relating to bruising for some residents were assessed and monitored on an ongoing basis with members of the MDT. This helped to ensure residents' protection.

The protection of residents was further promoted through staff training, discussions about safeguarding at team meetings and ongoing review of incidents. Residents had access to easy-to-read documents on a range of topics, including safeguarding. Consultation with residents occurred on an individual daily basis through residents' preferred communication methods. Staff spoken with appeared knowledgeable about residents' likes and preferences about how they lived their lives.

In summary, Aras Aoibhinn was found to promote a safe service where residents' care and support were kept under ongoing review.

Regulation 10: Communication

The provider had an up-to-date policy and procedure in place for communication. Residents had access to technological devices, the internet, televisions, radios, music players and telephones in line with their individual preferences. During the evening, one resident was observed to be content while watching their preferred programme on their technological device.

All residents living in the centre required some supports with communication. Residents' communication needs were assessed and communication profiles developed. Through observations, a review of care plans and discussion with staff members, it was clear that various forms of communication tools were used with residents to consult with them and to help them to make choices in their day-to-day lives. Augmented forms of communication used in the centre included; objects of reference, pictures and symbols. In addition, one resident had been supported to trial the use of a technological device and it was reported that they chose not to continue with this.

Judgment: Compliant

Regulation 12: Personal possessions

The centre had facilities for laundry and residents could launder their clothes as they wished. Residents were supported to retain access and control of their belongings. Residents had individual bedrooms that had space for storage of personal belongings. This included the safe storage of residents' finances, medication and personal files.

The provider had a policy and procedure in place for 'person supported monies'.

Residents had their own bank accounts. Financial assessments were completed to establish the supports residents required in managing their money. Regular checks were completed by the staff and management team to ensure that records of finances were well maintained.

Residents had an inventory of their personal belongings. However, the following was found:

- From a review of two residents' records, including a document to record 'service-user property', it was not clear that residents' records were kept up-to-date. For example; the last entry for residents' items bought, were March 2021 and May 2022. Since then, one resident had purchased a sliding wardrobe for their bedroom. In addition, it was not clear at what threshold of spending that personal possessions should be recorded. When asked, the inspector was informed that anything over EUR 200 should be noted. However, some entries on these records were of a lesser amount. On review of the provider's policy and procedures, it did not provide sufficient guidance on what the arrangements were to ensure the protection of residents' possessions. Improvements in this area would help to ensure that inconsistencies in records are addressed. This would also further promote the protection of all residents' property.

In addition, the following was found;

- Through a review of one resident's personal file, it was noted that they bought a sliding wardrobe for their bedroom. This was discussed with them at a review meeting on 23/01/2024. The minutes of this meeting said that the resident consented to spending EUR 3800 on this wardrobe for their bedroom. A social story was developed to support with this information. However, the resident's financial support assessment that was completed on 17/01/2024, assessed that they would not understand the 'purpose of money'. When asked if the resident would understand the value of this amount in comparison to other lesser amounts, the local management team said that they would not. Therefore, it was not clear that residents were provided with sufficient support, and time, to understand and manage their finances, particularly in situations where spending amounts were high.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Overall residents were found to be supported to enjoy meaningful activities in line with their preferences and developmental needs.

Residents were supported to take part in a range of individual leisure and recreational interests. These included activities in the house such as; using exercise equipment, baking and relaxing in the sensory garden. Residents were also

supported to do activities in their local community. These included; swimming sessions at local hotels, visiting the sensory room in the local library, spa treatments, reflexology, going on day trips to various locations and having meals out.

One resident attended a local day service during the week also. Two residents were supported to do activities from their home. The inspector was informed that following the COVID-19 pandemic in 2020, two residents chose not to return to their external day service when services opened up again. This was facilitated by the provider and residents now enjoyed doing activities from their home. In addition, they could link in with the nearby day service for activities, if required. For example, on the day of inspection one resident had attended the day service to use the sensory room.

In addition, links with family members and the wider community were promoted and encouraged. For example; one resident frequently enjoyed keeping in contact with family through a 'whatsapp' group.

Judgment: Compliant

Regulation 17: Premises

The premises was designed and laid out to meet the needs of residents. The house was clean, homely, spacious and well maintained. There were suitable facilities for laundry. The kitchen was spacious and well equipped. The layout of the kitchen and dining area created an accessible space for preparing and cooking meals.

Residents had their own bedrooms which were personalised with individual personal effects and belongings. Each bedroom had space for residents to safely store personal possessions. There were nicely decorated communal rooms for residents to relax in. Each resident was observed relaxing in a preferred area of the communal rooms, which were decorated and equipped with items of interest. For example, one corner of the room was decorated with relaxing sensory equipment that one resident was reported to prefer. Outside, the garden space and grounds were spacious, well maintained and accessible. There was a beautiful sensory garden created to the side of the house, which was accessible through double doors from the communal area.

The design of the house promoted accessibility for residents. There were ramps and handrails at exit points. Bathrooms and corridors included handrails for ease of movement. Residents had aids and appliances as required in line with their assessed needs.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide in place which contained all the information for residents that was required under this regulation.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The provider had a policy and procedure for admissions, transfers and discharge of residents. This outlined the procedures for supporting residents as they transfer between services and when they were absent from the centre. For example; if a resident required a hospital admission. This included guidance to ensure that important information relating to residents' care was transferred with them, to ensure the safe continuity of their care. Residents' had up-to-date 'hospital passports' in place which included important information about their needs, likes, dislikes and communication preferences.

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 risk management arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection two actions were completed and one was in progress.

The completed actions related to ongoing quarterly reviews of incidents by the incident monitoring and oversight committee and an action relating to incident management training.

The following action was in progress and not yet completed:

- The roll out of the revised risk management policy and procedure. The inspector was informed that a trial of training was completed by the provider, with further training events to occur when the policy was finalised. The local management team spoke of the benefit of the training to them. They said that the new risk management procedures would facilitate a more specific and user friendly risk register, which will be monitored by the provider. In addition, the new online system would allow for the provider to more

effectively see what the organisation's top risks are for example.

Within this centre, risks were well managed. There were safety statements and emergency plans in place. In addition, there were assessments in place for any identified risk. This included risks that could affect residents. For example; residents had care plans in place called a personal risk management plan (PRMP) which provided an assessment on any risks to them and their wellbeing.

In addition, regular reviews of incidents were completed by the management team and learning taken from any trends. For example; increased monitoring of medication had been implemented in response to a trend in medication errors.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were good arrangements in place for infection prevention and control (IPC) in the centre. Staff had undertaken training in various IPC modules. The premises were found to be clean and well maintained. There were arrangements in place for waste management and for completing laundry. There were colour coded mops and cloths to reduce the risk of cross contamination. In addition, there were suitable facilities to promote good hand hygiene practices, including ample sinks and soap, hand sanitisers, hand washing notices, and disposable paper towels.

Judgment: Compliant

Regulation 28: Fire precautions

The provider ensured that there were good arrangements in place for fire safety in the centre. These included; regular fire drills, a fire alarm system, fire fighting equipment, emergency lights and fire doors. In addition, staff received training in fire safety and emergency evacuation methods. For example; staff were given training in the use of evacuation sheets to evacuate residents.

Regular checks were completed on the fire safety arrangements by the staff team and local management team. This ensured that actions were identified in a timely manner. Each resident had a personal emergency evacuation plan (PEEP) in place to guide staff in the supports required, as relevant. A review of fire drills demonstrated that residents could be evacuated to a safe location under different scenarios.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that an assessment of need was completed for each resident. In addition, the health, personal and social care needs of residents were assessed regularly. Where the need was assessed, care and support plans were developed. These were kept under ongoing review and updated as required.

Annual review meetings were held to review residents' care and support. They included the maximum participation of residents and their family representatives, as relevant. In addition, residents were supported to identify and set goals for the future. These goals were found to be kept under ongoing review.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving behaviour support arrangements at the centre. The provider aimed to have all actions completed by 30/06/2024. At the time of the inspection the provider had completed five of these actions, with the other two reported to be in progress.

Actions that had commenced included the appointment of additional posts in psychology and behaviour support and the establishment of clinical and governance oversight committees. The policy and procedure for behaviour supports had been revised and procedures and referral pathways for MDT supports outlined. The inspector was informed that there was a new person commencing in the organisation after which the 'inter clinical team working policy' would be implemented.

The following action had commenced and was in progress at the time of inspection:

- 'neurodiversity' training programme for all staff

Within this centre, residents that required supports with behaviours and stress management had care plans in place. These were kept under reviewed by the MDT and changes made if required. A new template for behaviour support plans was in progress at the time of inspection. Staff had training in behaviour management. Where new staff had recently commenced, there were plans for them to undertake this training in the coming weeks.

Restrictive practices in place in the centre were kept under ongoing review. It was clear that every effort was made to safely reduce restrictions and to ensure that they were the least restrictive option for the shortest duration.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving safeguarding arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection, all actions had been implemented.

Within this centre there were good systems in place for monitoring incidents and injuries of an unknown origin (for example, bruises). This helped to ensure residents' protection. There were policies and procedures in place for safeguarding and for the provision of personal care. This provided guidance to staff about how to ensure residents are protected. In addition, there were notices on display around the centre about how, and to whom, to report abuse.

Residents had personal and intimate care plans in place which outlined clear guidance to staff on where supports were required and about how to give those supports.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was found to promote a rights-based service. Residents were consulted about their day-to-day lives through a range of communication methods, including social stories, pictures and objects of reference. Residents were also supported to practice their faith and visit religious amenities in line with their wishes.

Information on independent advocacy services was available in an accessible location in the house. This was in an easy-to-read format also. Residents had recently been referred for advocacy services to support them in making decisions about who they lived with.

There were a variety of easy-to-read documents on various topics. In addition, the use of social stories was used to aid residents' understanding in making decisions. For example; a social story was developed to support residents in making a decision about getting new bedroom furniture. While the service strived to consult with residents and establish their choices, as mentioned under Regulation 12: personal possessions, it was not clear that all options were explored to ensure effective and meaningful consultation with residents in making significant decisions about their spending.

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 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 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Aras Aoibhinn Residential Service OSV-0001751

Inspection ID: MON-0043060

Date of inspection: 05/09/2024

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Provider has restructured the Senior Management team to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management, and oversight.

Under the remit of the HSE's Service Improvement Team the Models of Service sub-group has been merged as part of the Quality, Safety and Service Improvement workstream. The Provider has devised a schedule of Provider visits to commence in mid-September 2024. The bi-annual thematic governance and quality improvement report was completed and circulated to the Senior Management Team on 12th August.

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

An organisational report is submitted to the provider from the senior management team through the Chief Executive Officer every 2 months. A fortnightly Huddle takes place with updates on actions from: CEO; QSSI, HR, Operations, Properties and Facilities, Finance and others as required. This is communicated across the organisation through a flyer document.
The provider has submitted a business case to the commissioner of services to strengthen the current on-call arrangement. An Organisational On Call Arrangement to be implemented in Q4 2024. Currently stakeholder engagement is ongoing,

implementation phase will commence as soon as stakeholder engagement has been completed.

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.

The development of compliance plans will now be completed in collaboration with the Person in Charge, Area Manager, Head of Quality and Safety and Service improvement and Head of Operations. 31/01/2025

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

The PIC will review and update all records of "Person Supported property logs" to ensure they capture all possessions purchased by each resident. To be completed by 25/10/2024

The PIC will ensure all staff read and understand the "Person Supported Monies "policy. This will be shared with the team at the next Team meeting. To be completed by 04/11/2024

The PIC will ensure that all purchases follow the guidance within the "Person Supported Monies" policy and monitor same through Monthly financial audits. Commencing 08/11/2024.

Going forward the Person in Charge will ensure that the appropriate support from Speech and Language therapy is made available to the resident when considering significant purchases.

The PIC will ensure that significant purchases follow the guidance in the "Person Supported Monies" Policy. This will give the resident the support and time required to decide on purchases.
In instances where it is deemed necessary by, PIC, S&T and Management, that additional support is required, the PIC will engage with an Independent advocate, or, if in place, the support from the Decision Supports services.

The Provider will review the Person Supported Monies Policy to ensure it clearly provides the guidance required to support residents with their money and provide clear escalation processes for purchases depending on the amount to be spent. To be completed by 27/06/2025.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports.
The training module on the revised incident management framework policy commenced on the 15/05/ 2024. The risk management policy and associated training module are in consultation stage with various stakeholders for organisational implementation. The Risk Management Framework 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.

31/01/2025

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The Governance and Clinical oversight Group has been renamed as the Critical Response Team and meets on a quarterly basis. The Neurodiversity training module commenced and is being rolled out to all staff in the organisation with refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and the Listening and Responding Policy has been reviewed and will be considered by key stakeholders including the Chairperson of the Rights Review Committee. The Inter Clinical Team Working policy will be implemented once the Clinical Lead has commenced in their position. To be completed 30/11/2024.

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	27/06/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2025
Regulation 26(2)	The registered provider shall ensure that there	Substantially Compliant	Yellow	31/01/2025

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/11/2024