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:	Cois Locha Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	25 June 2024
Centre ID:	OSV-0001773
Fieldwork ID:	MON-0043017

About the designated centre

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

Cois Locha provides a residential services to four adults. The service supports both male and female individuals with intellectual disabilities that present with associated complex needs such as physical and sensory disabilities and consequently have high support needs. The centre is a single-storey house on the outskirts of a rural village. All residents in the centre have their own bedrooms. The physical design of the building suits the needs of residents and there is suitable equipment available to support individuals with physical disabilities. Residents are supported by a staff team that includes the person in charge, social care workers and social care assistants. Staff are based in the centre when residents are present and there are both waking and sleep-in staff on duty at night to support residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 25 June 2024	10:45hrs to 17:30hrs	Alanna Ní Mhíocháin	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 wellbeing 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 Health Information and Quality Authority (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 the inspection the provider had completed a number of actions while others had been commenced and were in progress.

In this centre, residents received a good quality service that was in line with their needs. Staff were very knowledgeable on the supports required by the residents. The premises were well suited to the needs of residents. Residents were supported to engage in activities that they enjoyed. However, improvement was required in relation to the audit tools and procedures in the centre. Some improvement was also required in relation to the identification and assessment of restrictive practices in the centre.

The centre was a large bungalow in a rural location. It was located a few minutes' drive from a large town. Each resident had their own bedroom. One bedroom had an ensuite bathroom with a level access shower. There was also a large shared bathroom with level access shower. The house had a kitchen-dining room, sitting room, utility room, staff sleepover bedroom, and staff office. The centre also had a detached garage. This was used as a laundry.

The centre was clean, tidy, warm and bright. The house was very nicely decorated and in a very good state of repair. Each of the resident's bedrooms were decorated in different styles in line with their interests and tastes. Their photographs and belongings personalised their rooms. Each resident had ample storage for their clothing and possessions. The house was equipped to meet the residents' needs. Residents' rooms had tracking hoists in the ceiling and electric, adjustable beds. Tracking hoists were also located in the ceiling of the bathroom and in the sitting room. This gave more flexibility to the residents in relation to transferring between chairs. The house had been adapted to suit the specific needs of the residents. For example, the kitchen table was specifically made to accommodate the residents' wheelchairs. The front and rear of the house were accessible by wide ramps.

Photographs were located at the residents' eye level. Outside, the gardens and grounds were very well maintained and accessible to residents. A garden with level paving was located to the rear of the house. Herbs and plants were chosen due to their colour and smell to enhance the residents' experience in the garden. The person in charge reported that there were plans to repaint the outside of the house in the coming months.

The inspector briefly met with all four of the residents on the day of inspection. Residents were supported by staff during these interactions. The person in charge introduced the inspector to the residents and explained the purpose of the inspection. Staff supported residents with their activities of daily living and to move through the house, as they wished. Staff were heard chatting with residents. Staff could interpret the residents' individual communication strategies. A multisensory system was in place to support residents with their communication. Objects were kept in boxes by the front door of the centre. The objects were given to the residents to support their understanding of the next activity that would be undertaken. A different scent was used each day to orient the residents to the day. Specific music was played at different times to signify transitions from one activity to another. The inspector noted that staff played a particular song when residents returned home from day services.

In addition to the person in charge, the inspector met with four other staff members. Staff spoke about residents with care and respect. Staff were knowledgeable on the residents' needs and supports required. They could outline residents' preferences and dislikes. Staff had completed training on human-rights based care and outlined how they offered choices to residents throughout the day. Staff knew how to respond if a safeguarding incident occurred and how to report it. One member of staff was undergoing induction and they spoke about the supports and supervision that was in place as part of this process.

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

There were clear lines of management in this centre. The staffing arrangements were suited to the needs of residents. The provider had implemented a suite of audits and incident review procedures to maintain oversight of the service. However, improvement was required in order to ensure that local audits were specific to the needs of the service and adequate to identify all areas of service improvement.

The inspection was facilitated by the person in charge. They were very knowledgeable on the needs of the residents and the requirements on the service to meet those needs. The team of staff were also knowledgeable on the needs of residents. They could outline the supports that they implemented to meet the

residents' health, social and personal needs. The number and skill-mix of staff on duty ensured that residents were supported with their personal care and to engage in social activities. Staff training was largely up to date, especially in areas that had been identified as high-risk in this service. Staff received regular supervision. They were knowledgeable on who to contact if any issues arose. However, the on-call arrangements in the centre for staff to contact a member of senior management required review. The existing system was not adequately robust to ensure that staff could receive a timely response if an issue arose outside of regular hours.

The provider maintained oversight of the service through the review of incidents. Incidents were reviewed every quarter to identify trends and to avoid reoccurrence. Oversight of service quality was through a suite of audits that were completed in the centre. These audits were completed quarterly by the person in charge. However, the quality of information recorded did not always drive service improvement or identify actions that were measurable, specific or time bound. Senior managers also completed unannounced audits of the service every six months. These audits were more specific in recording the actions that needed to be undertaken in order to improve service quality. Specific actions were identified with a named person responsible and a timeline for completion.

The provider had submitted the necessary documents to apply for the renewal of the registration of this centre. These documents were reviewed by the inspector and found to be complete and contain the information required under the regulations. The provider had made arrangements to submit notifications to the Chief Inspector in line with the regulations.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted the required documentation to apply for the renewal of the registration of the designated centre. This was reviewed by the inspector and found to be complete.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge had the required qualifications and experience for the role. They maintained a regular presence in the centre. They had very good knowledge of the needs of the residents and the service.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangements were suited to the needs of the residents. The inspector reviewed the staff rosters for the three weeks prior to the inspection. This indicated that the required number and skill-mix of staff were on-duty at all times. The person in charge reported that there was one staff vacancy in the centre but that this had been filled on a temporary basis with a regular member of staff. Staff were familiar to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified 11 training modules for staff in this centre. The inspector reviewed the training records and noted that staff had up-to-date training in all areas. Where refresher training was required, this had been identified by the person in charge and staff had been listed to complete the training

Judgment: Compliant

Regulation 22: Insurance

The provider had submitted details of their insurance as part of the application to renew the registration of the centre. This was reviewed and found to include all of the details required under the regulations.

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 January 2024. At the time of the inspection, seven actions had been implemented with the remainder in progress.

Completed actions included:

- a review of senior management structure

- a reconfiguration of service areas
- the development of a service improvement framework and team. Quality improvement workstreams had been identified and the heads of the workstreams were due to meet quarterly. The Service Improvement and Oversight Committee met on 18 June 2024.
- scheduling of six-monthly unannounced audits of centres and allocating a manager from outside of the region to complete these audits.
- the re-establishment of an incident review committee. This committee issued quarterly reports on the incidents that had occurred across the service.
- the development of a standardised monthly reporting template
- the Human Rights Committee had been established

The five actions that were in progress can be summarised as follows:

- The assessment and review of frontline staff was ongoing. The on-call arrangements had not yet been finalised.
- The review of audits was ongoing. A new template for the six-monthly unannounced visits had been devised. However, a review of audits used within centres had not been commenced.
- The new staff training system was piloted in two areas. A roll-out of the new system was scheduled for the whole of the organisation in the next quarter.
- 115 staff had attended regulatory information events by 31 May 2024. Further dates had been scheduled in July, August and September.
- The provider had completed the final draft of the policy and procedure framework but this had not yet been circulated to staff.

In this centre, there were clear governance structures. Oversight was maintained through a suite of audits and incident reviews. However, improvement was required to on-call management arrangements and the quality of information recorded through audit.

The lines of accountability were clearly defined in the centre. Staff knew who to contact should any issues arise. Staff received regular supervision in line with the provider's guidelines. Supervision records indicated that all staff had completed a supervision session in the month of June or were scheduled to do so before the end of the month. However, as outlined above, the on-call arrangements for contacting a member of management required improvement. There was a system whereby managers were listed by hierarchy and staff were directed to begin by contacting their immediate line manager. If that manager was unavailable, staff were directed to continue to the next level of management until they received a response. This meant that managers were effectively on-call at all time and that the director of operations had to be contactable at all times. This was not adequately robust to ensure that staff could always get a timely response to issues that might arise outside of regular business hours.

Oversight of the service was maintained through a number of audits that were completed every quarter. The inspector reviewed the audits that were completed at the end of 2023 and the first quarter of 2024. The audits were completed in line with the provider's guidelines. However, the audits were generic and not specific to

the needs of residents in this centre. Further, the quality of information obtained through the audits was not always appropriate to identify areas for service improvement. For example, the financial audit listed tasks to be completed rather than questions that identified areas for service improvement. Where issues were identified on audit, it was not always clearly documented that actions had been taken to address these issues and the person responsible for the actions was not recorded. The person in charge reported that an informal process existed to complete actions but there were no written records to track actions or to identify that they had been completed.

The provider had completed six-monthly unannounced audits of the centre. The most recent audit had taken place in February 2024 and was completed using the new template. This audit identified 11 actions that needed to be completed There was a named person identified as responsible for completing the action and a target timeline for completion. The person in charge had written updates on the audit as they were addressed. There was evidence that the actions were addressed within the target timeframe.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had submitted their statement of purpose as part of the documentation required to renew the registration of the centre. This was reviewed by the inspector and found to contain the information outlined in the regulations.

Judgment: Compliant

Regulation 30: Volunteers

The person in charge reported that one person volunteered in the centre. The inspector reviewed the documentation that the person in charge maintained in relation to the volunteer. The person in charge completed regular supervision with the volunteer. The volunteer's role was clearly defined. A Garda vetting form was kept on file for the volunteer and updated every three years.

Judgment: Compliant

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

The person in charge had not been absent for more than 28 days during the current registration cycle. The provider was aware of their obligation to submit notifications in relation to the absence of the person in charge under this regulation.

Judgment: Compliant

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

The application form for the renewal of the registration of the centre included information about the procedures and arrangements that were in place should the person in charge be absent for more than 28 days.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints procedure. This was on display in the centre in a prominent location. The person in charge reviewed any complaints in the centre on a quarterly basis.

Judgment: Compliant

Quality and safety

There was a good quality service in this centre. The resident's needs were assessed and appropriate supports put in place to meet those needs. The resident's safety was promoted through good safeguarding procedures and risk management. However, some improvement was required to ensure that all restrictive practices were identified and assessed.

The residents in this centre were in receipt of a person-centred service. This was reflected in the way that the house had been laid-out and equipped to meet the needs of residents. The staff were knowledgeable on the supports required by residents. The residents had access to a variety of healthcare professionals in relation to their health, social and personal needs. Residents were supported to engage in activities in the centre and the wider community that were in line with their wishes and preferences.

Residents were kept safe in this service. Staff had up-to-date training in safeguarding. The provider had implemented measures to protect residents from the

risk of infection. Risk assessments had been devised to reduce risks to residents. Some restrictive practices had been introduced in relation to residents' safety. However, not all restrictive practices had been fully assessed in order to ensure that they were the least restrictive measures possible.

Regulation 10: Communication

Residents were supported to communicate their needs and wishes in this centre. Staff were knowledgeable on the residents' communication styles. A speech and language therapist had provided recommendations to staff to support residents with their communication. Systems using objects and non-verbal methods had been implemented in the centre. This was observed throughout the inspection. For example, a member of staff was observed offering a resident a choice of milk or juice by showing the resident the two cartons and interpreting their response.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to engage in activities that were in line with their interests. The inspector reviewed the notes from January to April 2024 for two residents in relation to their social outings. These indicated that the residents were supported to engage in activities within the centre and the wider community. For example, residents were supported to go on day trips, visit religious sites, attend football matches, go bowling, go to the theatre, and go for meals out.

Judgment: Compliant

Regulation 17: Premises

As outlined above, the centre was very well suited to the needs of the residents. The lay-out of the house and the equipment provided meant that residents' daily needs could be met. There was adequate private and communal space. The centre was nicely decorated and in a very good state of repair. The house was fully accessible to all residents.

Judgment: Compliant

Regulation 18: Food and nutrition

The nutritional needs of residents were well managed. Staff were knowledgeable on the residents' nutritional needs and supports required. Staff were observed preparing foods and fluids that were in line with the residents' nutritional needs. Staff knew the specific supports that were required by residents at mealtimes. They knew how to ensure that foods and fluids were of the correct consistency when they had meals in a restaurant. They reported that meal options were available for residents. Residents had access to relevant healthcare professionals in relation to their nutritional needs as evidenced from their notes. Follow-up referrals were made to these professionals, as needed.

Judgment: Compliant

Regulation 20: Information for residents

The provider had developed a guide for the resident. This was reviewed by the inspector and found to contain the information set out in the regulations.

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 at the centre. The provider aimed to have all actions complete by 31 October 2023. At the time of the inspection, one action had been completed and two had commenced and were in progress.

The action that had been completed was:

- incidents were reviewed on a quarterly basis by an incident review committee.

The actions that were in progress were:

- training in incident management had been delivered to senior managers and to persons in charge of some centres in the organisation. The person in charge of this centre had completed this training.
- the risk management policy had not yet been finalised

In this centre, the provider had implemented adequate risk management systems.

The inspector reviewed the individual risk assessments for two residents. These assessments had been reviewed recently. They were comprehensive and gave clear guidance to staff on measures that should be taken to reduce the risks to residents.

The person in charge maintained a risk register for the service as a whole. This had been reviewed in April 2024 and was comprehensive. It outlined the measures that should be taken to reduce risk and the risk assessments were appropriately risk rated.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had taken steps to protect the residents from the risk of infection. Infection risks had been identified. There was clear guidance to staff on the measures that should be taken in relation to hand hygiene, the wearing of personal protective equipment (PPE), and the segregation of waste. The required process for cleaning pieces of equipment were outlined in care plans and risk assessments.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The assessments of need and personal plans had been completed for residents.

The assessments and personal plans of two of the four residents were reviewed by the inspector. An assessment of the needs of the residents had been completed within the previous 12 months. This included an identification of the residents' health, social and personal needs. Guidance documents for staff based on these assessments were provided.

An annual review of the residents' personal plans had taken place. These meetings included a review of the residents' previous goals and set new personal goals for the year ahead. These were updated by a member of staff every 4 months.

Judgment: Compliant

Regulation 6: Health care

The healthcare needs of residents were well managed in this centre. Residents had access to a wide variety of healthcare professionals. There was evidence that staff followed-up on recommendations made by healthcare professionals and made referrals as residents' needs changed. Staff were knowledgeable on the residents' health needs and the supports they required. Residents had a named general practitioner (GP).

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 governance arrangements at the centre. The provider aimed to have all actions complete by 30 June 2024. At the time of the inspection, five actions had been completed and two were in progress.

The completed actions included:

- an interim head of clinical and community support had been appointed
- additional multidisciplinary team practitioners had been employed
- a critical response team was established to review the placement of residents when required
- a behaviour oversight committee was re-established
- access to appropriate multidisciplinary team supports had been finalised and the standardised template for behaviour support plans had been finalised.

The actions that were in progress included:

- the policy on the role of psychology and interdisciplinary team working had not yet been finalised
- the training modules on neurodiversity had been rolled out to managers with plans for staff in designated centres to received training in the coming weeks

In this centre, the provider had made arrangements to support residents to manage their behaviour. However, improvement was required in relation to the identification and assessment of all restrictive practices.

The person in charge had ensured that staff had up to date knowledge on the supports required by residents to manage their behaviour. Supports required by residents were outlined in their risk assessments. A member of the organisation's behaviour support service had provided bespoke training in relation to certain practices in the centre.

The provider had identified restrictive practices that were used in the centre and these were recorded and reviewed. However, the practice of completing night-time checks of residents every 20 minutes had not been identified as restrictive. As a

result, this practice had not been assessed and reviewed in order to ensure that it was the least restrictive practice possible and used for the least amount of time.

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 governance arrangements at the centre. The provider aimed to have all actions complete by 31 October 2023. At the time of the inspection, all of these actions had been completed.

The completed actions included:

- a new system was in place to improve staff awareness of the safeguarding process. The agendas for all team meetings in the centre included safeguarding as a standing item.
- active safeguarding plans were reviewed on a quarterly basis
- a safeguarding oversight committee had been established
- the safeguarding policy had been reviewed
- face-to-face training in safeguarding had commenced. All staff in this centre had received this training.

In this centre, the provider had arrangements in place to protect the residents from abuse. Staff in the centre had all completed face-to-face safeguarding training in addition to an online safeguarding training course. They were knowledgeable on the steps that should be taken in the event that a safeguarding incident occurred. Safeguarding was included as a standing item on team meeting agendas.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	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
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cois Locha Residential Service OSV-0001773

Inspection ID: MON-0043017

Date of inspection: 25/06/2024

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 revised the unannounced visit template and unannounced visits are scheduled up to 31/7/2024. The next bi-annual thematic governance and quality improvement report will be presented to the Board at the end of July.

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

An organisational report is submitted to the provider from the senior management team through the Chief Executive Officer every 2 months. A fortnightly Huddle takes place with updates on actions from: CEO; QSSI, HR, Operations, Properties and Facilities, Finance and others as required. This is communicated across the organisation through a flyer document.

The pilot on Viclarity has commenced since 31st July 2024 with Senior Management, Senior Operation Managers, Frontline Managers and staff in a number of Residential,

Respite, Day and Community supports Services including 3 Hiqa sites.

The Managers will be specifically piloting the Audits on Medication and Staff files in the first instance. It is envisaged to upload all audits on the Viclarity system pending learning and feedback from the initial two audits from the Persons in charge.

The pilot will be running for up to three months at which stage all other audits will be uploaded and reviewed as to fit for purpose to improve the quality of the audit management system using the feedback of the Managers. The system will allow for generation of a report of quality improvement for the service based on the actions raised.

The provider has submitted a business case to the commissioner of services to strengthen the current on-call arrangement. An interim arrangement for on call is in place across a number of service areas and some discussions are ongoing in one area. In addition, the provider is working to provide an interim on call arrangement across all Areas and Departments. In this Area the interim on call arrangement will be in place from the 05/08/2024

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 will be presented to the QSSI workstream for stakeholder engagement. Following consultation, a draft framework and training module will be presented to the Senior Management Team which will include stakeholder feedback on the 23/07/2024.

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

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC will carry out an assessment on the practice of night time checks of the people supported in the service.

• The assessment will consider the practice of night time checks by staff while taking the

needs of the individual's and their will & preference into consideration, while also upholding our duty of care for the individual's.

• We will assess that the practice of night time checks is proportionate to the risks it is being used to prevent, while ensuring we are considering the least restrictive option for the shortest possible time and that any practice in place following the assessment will be subject to timely review.

We will also request the Rights Review Committee to assess the practice of night time checks in the service. The Rights checklists will be updated for each individual and sent to the Rights Review Committee for analysis and feedback.

The Governance and Clinical oversight Group has been renamed as the Critical Response Team and meets on a quarterly basis. The Neurodiversity training module commenced and is being rolled out to all staff in the organisation with refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and the Listening and Responding Policy has been reviewed and will be considered by key stakeholders including the Chairperson of the Rights Review Committee on the week commencing 15/07/24 prior to implementation. The Inter Clinical Team Working policy will be implemented once the Clinical Lead has commenced in their position.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	30/08/2024
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	30/08/2024
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's	Substantially Compliant	Yellow	30/09/2024

	behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			