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:	Hillcrest Apartments
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	18 June 2024
Centre ID:	OSV-0001780
Fieldwork ID:	MON-0042095

About the designated centre

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

Hillcrest Apartments is centre run by Western Care Association. The centre can provide residential care for up to three male and female residents who are over the age of 18 years with an intellectual disability. The centre comprises of a two-storey house which contains three separate apartments located in a village in Co. Mayo. Each apartment provides residents with their own bedroom, bathroom, hallway and kitchen and living area. Residents also have access to a large garden area. Staff are on duty both day and night to support the residents who live at 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
Tuesday 18 June 2024	10:30hrs to 17:00hrs	Catherine Glynn	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 registration of the centre. Overall, this inspection found that residents were supported with their health and wellbeing by a dedicated staff team.

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 had been published on the HIQA website. In response to the findings of this review, Western Care Association submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have commenced a programme of inspections to verify 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 more in progress for completion. These will be discussed under each regulation later in the report.

The centre provided residential care to three residents. The centre comprises of one house converted into three self contained apartments to provided an individualised programme for each resident. Staff were on duty supporting each resident in line with their assessed needs and the daily programme in place.The inspector was met by the assistant manager and was informed that the person in charge was on leave that day. The inspector found the assistant manager very knowledgeable, calm and they spoke about their qualifications and experience. Overall, the assistant manager was found to be very knowledgeable and had worked in various roles with all of the residents and in the organisation. The inspector provided their identification on arrival to staff and a copy of the "nice to meet you" document was provided should any resident require this service user friendly sheet explaining the inspection. The inspector was advised that two residents were completing their activities as scheduled, this included one resident attending their day service programme and another resident engaging with their home based activity programme in the community. Another resident was at home with staff and the inspector met and observed them during the walkaround of the centre. The inspector noted that this resident was very relaxed and calm, whilst enjoying floor activities and staff were present and available to this resident. Later on that morning the inspector was advised that another resident had returned and was invited into their apartment for a brief chat. Again, the inspector noted the ease and confidence of staff in their interaction at all times with this resident. The inspector was also talked through the vocalisations they had heard and this was also reflected in the residents' personal

plan reviewed. The inspector was unable to meet the third resident as they were attending their day programme during the inspection and returned briefly before going out in their local community for another planned activity, such as a walk and refreshment. At all times, staff were heard speaking and interacting in a professional and respectful manner whilst offering choice and assistance. Staff were also found to be knowledgeable of the residents preferences and communication styles.

In all three apartments, each resident had their own bedroom which was beautifully decorated and personalised with soft furnishings and personal effects. Pictures, artwork and personal photos were displayed throughout each apartment. There was spacious communal areas to the front and rear of the centre.The assistant manager spoke about further plans to develop the outdoor area for example a sensory swing.

There were easy to read documents available and on display in all three apartments with information on staff working, advocacy, safeguarding and menu plans. Residents also had access to assistive technology in line with their assessed needs.

Overall, residents receiving residential care were found to be supported by a committed staff team and were supported to achieve good health and wellbeing.

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

Overall, this inspection found that the service was managed by a dedicated management team, and staff team who knew the residents well. There were systems in place for monitoring the centre on an ongoing basis, to ensure that there was effective oversight of this centre and that all residents were supported in line with their assessed needs.

The governance and management arrangements were strengthened following the last inspection, this included a review of management regions, increase in local management with the addition of an assistant manager and enhanced corporate management structures with departments such as quality, training and an increase in behaviour support services. As said previously, the person in charge was on leave on the day of the inspection but the assistant manager was present and interacted with the regulator as expected and in a confident and professional manner. The inspector found that the management structure had settled in their roles and the person participating in management also attended and provided additional support and knowledge to the inspection. The inspector found that the new management changes had embedded into the service and roles. The service provided in Hillcrest apartments was person-centred while ensuring that alll residents were protected

from harm. The inspector found that in all of the regulations reviewed, the areas for improvement were linked to the providers compliance plan with seven actions remaining but from conversation with the management team these were all in progress. This will be expanded on later in the report under relevant regulations.

Staffing arrangements in place were reviewed as part of the inspection. A planned and actual roster was available and in place, which showed an accurate account of staff present at the time of the inspection. The provider had ensured that the number and skill mix of staff met with the assessed needs of residents and good consistency of care and support was provided.

The annual review of the quality and safety if the service was completed and up to date and showed relevant actions for completion, and was also linked with the providers compliance plan and additional actions identified from the provider led six-monthly unannounced visits which was recently completed in April 2024. Staffing in place was provided by a core team and regular staff meetings were taking place regularly, with a set agenda as a guide. A review of incidents occurring in the centre showed that they were recorded and reported within required timeframes but also analysed to monitor patterns and trends by the management team. All incidents where required were reported to the chief Inspector in line with the requirements of regulation 31. In addition, the inspector found that while the provider was aware of ensuring that appropriate arrangements were in place for the absence of the person in charge for a short term or a long term unplanned absence. The inspector found that there was a clear guideline for all staff in place in the event of an absence of the person in charge. The provider also understood their requirements to report any notifiable absence to the Chief Inspector as required by regulations 32 and 33.

Overall, the inspector found that the governance and management arrangements had significantly improved in this centre which, resulted in a safe and effective service was provided. This led to good outcomes for residents' quality of life and for the care provided in this centre.

Registration Regulation 5: Application for registration or renewal of registration

The provider had ensured that all the required documentation to support the application to renew the registration of the designated centre had been submitted within the specified timeframe.

Judgment: Compliant

Regulation 16: Training and staff development

The management team showed that an accurate training record was in place and monitored as required. Plans were in place for refreshers where required and a training needs analysis was completed to identify any additional training required, such as diabetes and epilepsy.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured that the centre was insured as required by the regulations and was available for review in the centre on the day of the inspection.

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, unannounced visits by objective personnel, quarterly incident reviews through the incident monitoring and oversight committee, regular regulatory training events and the re-establishment of a human rights committee.

In addition, the person participating in management spoke about a review of their role and governance structure recently, with recommendations made to put in place an assistant manager to support the person in charge, in their role. They felt that this would be of great benefit. In addition, the assistant manager said that they were planning on attending a regulatory training event that was being held in June. They also spoke about a new one day training for new staff that was completed in the main offices, and felt this would be of benefit to new staff.

Some of the actions in progress and not yet completed included; the implementation of a staff training and development plan and a review of the current suite of audits.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There were contracts in place which clearly laid out the services offered to residents and any charges incurred in the centre. All contracts were signed by a representative and a copy was available in the centre as required.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service provided in the centre. This was also provided in an accessible format for residents.

Judgment: Compliant

Regulation 30: Volunteers

The provider had a policy and procedure in place as required by the regulations. At the time of the inspection, the provider did not have any volunteers working in this centre due to the specialised support needs of the residents.

Judgment: Compliant

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

The provider was aware of the requirement to notify HIQA of periods of absence of the person in charge. No absences were anticipated at the time of the inspection.

Judgment: Compliant

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

The provider had ensured that arrangements were in place for the absence of the person in charge and had submitted this information as part of the application to renew the registration of the centre. This ensured that effective oversight was maintained for this centre at all times.

Judgment: Compliant

Quality and safety

The inspector found that the service provided in Hillcrest apartments was person-centred and residents were supported to live rewarding and active lives in their local community and centre.

The staff team ensured that the resident's health, personal ,and social care needs were assessed. Care and support plans were developed, as required. Meetings occurred with residents and their family representatives where priorities and goals were reviewed and agreed. Staff spoken with, talked about the activities the residents enjoyed which, included attending day services, trips on the transport provided and nights away with family.

As outlined residents required support with communication needs and minor behaviour support guidance. At the time of the inspection, all residents were reviewed by a behaviour support specialist but as seen from a documentation review, none of the residents required a formal behaviour support plan. At present, they were all receiving an informal process whilst the organisation was commencing a new behaviour support plan template. The inspector noted that the management team and staff were very familiar with all residents and their assessed needs in the centre. The policy on behaviour support was up to date and staff training was in place. Minimal restrictive practices were in place in the centre, and those that were in place were regularly reviewed and when agreed removed when no longer necessary.

There were systems in place for the management of risk, including risk assessments for identified risk relating to individual residents and a service risk register. In addition training was planned by the organisation to strengthen the risk management process. The provider had also ensured that there was a policy which contained all relevant information as specified by the regulations.

A review of safeguarding and protection in the centre found that there were no active safeguarding plans in place, however staff had knowledge of the of the process required in line with local and national policy. The safeguarding policy was up to date and all staff had completed training. Intimate care plans were completed

and available for review. The management team were clear about the procedures required if a concern arose and the identify of the designated officer was displayed in the centre.

The premises provided was clean, comfortable, suitably decorated and personalised throughout the designated centre. The provider had ensured that the premises met the assessed needs of residents and was monitored effectively to ensure that it was maintained appropriately.

In summary, residents at this centre received a good quality service where their independence and autonomy was upheld and promoted. There were good governance and management arrangements in the centre which led to improved outcomes for residents' quailty of life and care provided. Ongoing progress with the actions committed to by the provider on their compliance plan would further enhance the service and the quality of care and support provided.

Regulation 10: Communication

The provider had ensured that there was a policy on communication in place to guide staff in their practice. Residents were also provided with access to all relevant multidisciplinary supports to guide staff in their practice to support residents with communication needs.

Judgment: Compliant

Regulation 11: Visits

Visits were supported in this centre and records of visitors attending was in place. There was no limitations on visits in this centre and there was adeqaute room available throughout the centre to facilitate visits.

Judgment: Compliant

Regulation 12: Personal possessions

The provider had ensured that each resident in this centre had maintained control of their possessions in the centre. For example, each resident had their own bank account which was monitored and reviewed and that they had access to as required. Residents were also provided with all amenities in their apartments to ensure that

their independence was available or supported as required.

Judgment: Compliant

Regulation 18: Food and nutrition

The management team and staff ensured that residents had access to a nutritional diet, and to have choice of meals and snacks of their choice and preference in the centre. In addition, residents who required additional modified diets, staff had received all required training and guidelines were in place and were monitored by relevant MDT.

Judgment: Compliant

Regulation 20: Information for residents

The provider had ensured that a guide was in place for the centre which included a summary of the services and facilities provided, terms and conditions relating to the tenancy agreement in place, arrangements to access reports on the centre and arrangements for visits in the centre.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The provider had procedures in place for the temporary absence, transition and discharge of residents to ensure that residents were supported in line with their assessed needs.

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 the 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.

Actions completed included a review of the risk management policy and the introduction of a quarterly process of incident review.

The inspector found that one action in relation to incident management training was in progress.

In this centre, the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies. Policies on risk management were available for review and safety statements were up to date. Risk assessments for service level risks were in place and each resident had a personal risk management plan.

Judgment: Substantially 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 in the organisation. The provider aimed to have all actions completed by 30/06/2024. At the time of the inspection the provider had completed six of these actions. The seventh action had commenced and was in progress.

Completed actions included the appointment of an interim head of clinical and community support and the appointment of an additional multi-disciplinary supports. Under the leaderships of the psychology team, a governance and clinical oversight group and a behaviour support oversight group was established in order to coordinate the response to critical incidents. A review of the role and function of the psychology team was completed and guidance on the referral pathways was developed.

The inspector found that one action was in progress. The training module in neuro-diversity was developed, a pilot was completed and the full role out of the training module had commenced with management and some staff staff at the time of the inspection.

In this centre, the inspector found that residents had required support with positive behaviour support had specialists support in place. The policy on behaviour support was up-to-date and staff training was provided.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider 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 were completed.

These included the establishment of a safeguarding oversight committee, updating of the providers safeguarding and protection policy and the introduction of a six monthly review system for open safeguarding plans. In addition, staff had access to face to face training in all safeguarding and protection and protection and new systems were in place to improve staff awareness of the contents and actions of open safeguarding plans.

At this centre, the inspector found that residents were supported to understand the need for self-care and protection. If safeguarding plans were required, the inspector found that the management team had a good awareness of the plans requirements and that the actions were integrated into the behaviour support strategies and personal risk management plans.

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 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	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
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	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 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hillcrest Apartments OSV-0001780

Inspection ID: MON-0042095

Date of inspection: 18/06/2024

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 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.

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.

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 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.

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(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	30/08/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's	Substantially Compliant	Yellow	30/09/2024

	behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			