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:	Moy Services
Name of provider:	Health Service Executive
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	09 April 2025
Centre ID:	OSV-0005637
Fieldwork ID:	MON-0046607

About the designated centre

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

The centre comprises of two separate houses which are in close proximity to each other and support residents with a primary diagnosis of intellectual disability to live in the community. Residents may also attend the services of mental health professionals and may also have some medical needs. An integrated model of care is provided and residents are supported to be active in their local community. Each house had access to a vehicle, as well as public transport links such as trains, taxis and buses being within easy reach. Each resident had their own bedroom and there is ample communal, kitchen and dining facilities available for residents.
A social model of care is provided, with residents being supported by a combination of social care workers and healthcare workers, there are also some nursing hours allocated to the centre to meet residents' assessed needs. At night time, residents in both houses are supported by a night duty staff member.

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
Wednesday 9 April 2025	09:40hrs to 17:00hrs	Alanna Ní Mhíocháin	Lead
Wednesday 9 April 2025	09:40hrs to 17:00hrs	Mary McCann	Lead

What residents told us and what inspectors observed

This inspection was an unannounced focused inspection to review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and the National Standards for Adult Safeguarding (2019). It followed a regulatory notice issued by the Chief Inspector of Social Services in June 2024 in which the safeguarding of residents was outlined as one of the most important responsibilities of a designated centre and fundamental to the provision of high quality care and support. Furthermore, that safeguarding is more than the prevention of abuse, but a holistic approach that promotes people's human rights and empowers them to exercise choice and control over their lives.

Inspectors found that residents in this centre were supported to live meaningful lives and to engage in activities that were in line with their interests. The provider had systems in place in relation to safeguarding. However, inspectors found that the oversight and implementation of these systems required significant improvement. The provider had not identified or accurately processed safeguarding incidents in line with their own policies. The provider had not reported safeguarding incidents to the Chief Inspector in line with the regulations. Residents had recently moved out of the centre to address issues relating to compatibility. On the day of inspection, as a result of these actions, inspectors were assured that residents in this centre were safe and in receipt of a quality service that met their health, social and personal needs.

The centre consisted of two houses. These houses were located within the same large town a few minutes' drive apart. Both houses were located in housing estates and were within easy access of the town centre. They were near shops, restaurants, cafes, and other local amenities. Both houses were two-storey houses. The inspectors had the opportunity to visit both houses on the day of inspection.

Both houses were warm, clean and tidy. They were homely and comfortable. They were very nicely furnished and in a good state of repair. Each resident had their own bedroom. Residents' bedrooms were decorated in different styles. Residents had storage space for their personal items. The residents' bedrooms were personalised with their photographs and belongings. Each resident had their own bathroom. Some had an en-suite bathroom and others had use of the main bathroom in the house. The shared rooms in the house were large and decorated with artwork, some created by the residents. There was space for residents to spend time together or alone, as they wished. One house had three separate spaces for residents to relax; the main sitting room, a sun room and a third room that was developed into a relaxation and craft room for one resident.

Outside, there were nice gardens and outdoor spaces. One house had a shed in the garden that was used as a workshop by one resident. There was outdoor furniture and usable space. The fence surrounding the back garden of one house had been

damaged in a recent storm. The provider had plans to replace the fencing.

The centre was registered to accommodate five residents. One the day of inspection, only three residents were living in the centre. The inspection was facilitated by a member of senior management as the person in charge was on leave. The senior manager reported that two residents had recently moved to other designated centres. This formed part of the provider's safeguarding plan to reduce negative interactions between residents and to address compatibility between residents. One resident had moved out only two days previously. Some of the resident's belongings remained in the centre.

The inspectors had the opportunity to meet all three residents and spend some time with residents throughout the day. All residents reported that they were happy in their home. They said that the staff were nice. Residents said that they felt safe in their home. Residents spoke about their interests and the activities that they enjoyed in the centre and in the wider community. They spoke about holidays that they had taken and planned trips. One resident spoke about a new resident who was going to move into their home. They said that they did not know this person. The senior manager reported that a new resident for the centre had not yet been identified.

In addition to the senior manager, the inspectors had the opportunity to meet with three members of staff. Staff were knowledgeable on the needs of residents. They knew their favourite activities, preferred topics of conversation and the supports that they required. Staff were knowledgeable on the steps that should be taken should a safeguarding incident arise. Staff chatted comfortably with residents. They responded quickly when residents asked for help. They offered choices to residents and respected those choices. When residents requested to go on an outing, staff responded quickly and supported the resident to complete the activity.

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 affect the quality and safety of the service provided.

Capacity and capability

Significant improvement was required in relation to the management and oversight of safeguarding systems in the centre. The centre was adequately staffed to meet the needs of residents.

The oversight arrangements in the centre required significant improvement. Though audits and incident reviews occurred on a regular basis, these arrangements had not identified issues in relation to the reporting and processing of safeguarding incidents. These were identified by inspectors on the day of inspection. The service improvement actions recorded on the centre's annual review were not specific. This meant that it was not possible to measure improvement in the service or progress

towards a goal. They were also not reflective of the safeguarding issues that were happening in the centre at the time.

The staffing arrangements in the centre were suited to the needs of residents. Residents were supported by a consistent team of staff who were familiar to the residents. Staff were knowledgeable on the needs of residents and had completed training in modules that were relevant to safeguarding and the promotion of the residents' human rights.

Regulation 15: Staffing

The staffing arrangements were suited to the needs of residents.

The inspectors reviewed the rosters from 1 April 2025 to 11 May 2025 and found that the required number of staff with the necessary skill-mix were available to support the residents. A regular team worked in the centre. This meant that staff were familiar to the residents. The inspectors noted that a planned and actual roster were maintained in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received training in modules that were suited to the needs of residents. This included modules that provided knowledge and skills to staff in relation to safeguarding residents.

The inspectors reviewed the training records in the centre. These indicated that staff had up-to-date training in safeguarding. The need for additional in-person training in safeguarding had been identified by the provider. There was a plan for all staff to complete this training by the end of April 2025. Staff had also received training in other modules that were relevant to the protection of residents; for example, training in human rights-based care.

The inspectors reviewed the modules that were identified for new staff undergoing induction. This showed that new staff were trained in the residents' specific safeguarding plans and behaviour support plans.

Judgment: Compliant

Regulation 23: Governance and management

The provider had implemented oversight systems to monitor that safeguarding procedures were implemented. However, improvement in these systems was required to ensure that all safeguarding incidents were identified and processed appropriately. Where the provider identified goals for service improvement in relation to safeguarding, improvement was needed to ensure that these goals were specific and measurable.

The provider had a system whereby incidents that happened in the centre were reviewed at a meeting twice weekly by the person in charge and senior management. However, when inspectors reviewed the incidents recorded in the centre for the first quarter of 2025 they found six incidents in January 2025 that had not been processed appropriately. Consequently this system had not ensured that all safeguarding incidents were identified and reported appropriately in line with the provider's policy. This will be discussed under regulation 8: protection.

The inspectors reviewed the routine audits that were completed in the centre. These audits included a review of areas that related to the safeguarding of residents. For example, monthly audits were completed in relation to complaints and restrictive practices. However, not all audits identified the issues relating to safeguarding that were identified by inspectors. For example, the monthly audits of incidents in the centre had not identified the actions needed in relation to the safeguarding incidents that occurred in January 2025.

The inspectors reviewed the most recent annual review into the quality and safety of care and support of the residents. This report was completed in November 2024. Two actions for service improvement relating to the safeguarding of residents were identified in this report. Neither of these actions were specific or time-bound. For example, one action stated "continue to prioritise safeguarding and maintain resident safety" with a time frame of 'ongoing'. The person responsible for this action was identified as the person in charge and all staff. This meant that progress towards this goal was not measurable.

Judgment: Substantially compliant

Quality and safety

Significant improvement in relation to the management of safeguarding was required to promote the safety of residents. Improvement in relation to the information provided to staff when supporting residents to manage their behaviour was also needed. Residents were supported to engage in activities that were in line with their interests and were in receipt of a service that met their health, social and personal needs.

The safeguarding systems in the centre to protect resident from abuse had not been fully implemented and improvement in this area was required. Though incidents

were recorded, they had not been processed in line with the provider's policy or reported to the Chief Inspector in line with the regulations. This meant that the effectiveness of the safeguarding plan and safeguarding arrangements in the centre were not adequately reviewed. Supporting residents to manage their behaviour formed part of the safeguarding arrangements in the centre. Though the provider had developed behaviour support plans for residents, these plans did not clearly outline the specific actions that should be taken by staff when supporting residents to manage their behaviour.

Residents were supported to engage in meaningful activities in the centre and in the wider community. The needs of residents had been adequately identified and the supports necessary to meet those needs had been implemented. The rights of residents were promoted.

Regulation 10: Communication

The provider had ensured that residents were supported to communicate their needs and wishes. Residents were supported to understand the choices offered to them and to express their preferences.

The inspector reviewed the communication profile for one resident. This was a detailed document that had been reviewed in January 2025. The document outlined the supports required by the resident to understand information given to them and the supports they needed to express their choices, preferences and opinions. The document outlined the resident's interests, preferred topics of conversation, and topics that the resident did not want to talk about. When staff spoke to the inspectors, they demonstrated very good knowledge of these supports and preferred conversation topics. Staff were observed following the strategies outlined in this communication profile when communicating with the resident.

Judgment: Compliant

Regulation 17: Premises

The premises were suited to the needs of the residents. The lay-out, space and facilitates were in line with the objectives of the service.

As outlined in the first section of the report, the houses were well maintained. They were nicely decorated and personalised with artwork and the residents' belongings. There was space for residents to spend time together or alone. There was space for residents to store their belongings. The houses had been set-up to support the residents' interests and hobbies. For example, one house had a room where a resident could complete their knitting projects and the other had an outdoor shed to

accommodate a resident's workshop.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had completed an assessment of the residents' health, personal and social care needs.

The inspectors reviewed the records of all three residents and found that a comprehensive assessment of the residents' health, social and personal care needs had been completed within the previous 12 months. The assessments identified the level of support required by the resident to meet their needs. Based on the assessments, care plans had been written to guide staff on how to support the residents. These care plans were regularly reviewed and kept up to date.

An annual review of the residents' personal plan had been completed within the previous 12 months. This review included the residents' views. The previous year's goals were reviewed and new targets set for the year ahead.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had made arrangements to ensure that residents were supported to manage their behaviour. However, the residents' behaviour support plans did not always give clear guidance to staff on what actions should be taken to ensure that residents were supported appropriately.

The inspectors reviewed one resident's behaviour support plan. This plan aimed to reduce negative interactions between residents. It had been developed by a suitably qualified professional. It was updated regularly. The most recent update had happened a few days before the inspection. Though the report described the resident's behaviours, it did not give clear actions to staff on what to do to support the resident to avoid negative interactions with peers.

Judgment: Substantially compliant

Regulation 8: Protection

The provider did not have effective systems in place to ensure that residents were

protected from all forms of abuse. Inspectors noted that the provider had not adhered to their own guidelines in relation to the identification of safeguarding incidents. Incidents had not been reported to the Chief Inspector in line with the regulations.

There was one open safeguarding plan in the centre on the day of inspection. The plan related to negative interactions between residents and had been developed in December 2024. It was due to be closed in the near future as one of the residents had moved out of the centre. The safeguarding plan was reviewed by the inspectors. They found that the plan outlined the safeguarding procedures that had been undertaken by the provider in relation to supporting the resident who was impacted by the actions of another, for example, meeting with a psychologist. However, the plan did not outline the specific actions that should be taken to avoid a reoccurrence of the incidents. It did not guide staff on the supports that should be offered to residents to ensure that incidents did not reoccur.

The inspectors reviewed the record of incidents that had occurred in the centre in January 2025. The inspectors noted six separate incidents where similar negative interactions had occurred in the centre despite the safeguarding plan being in place. This indicated that the plan was not effective.

In addition, the incidents had not been reported to the Chief Inspector, as discussed previously under regulation 23. The notifications were submitted to the Chief Inspector following the inspection at the request of the inspectors. The records and notifications indicated that the incidents were discussed at the provider's incident triage meetings. However, they had not been reported to the safeguarding and protection team in line with the provider's policy. As these incidents were not reported and processed appropriately, it meant that the effectiveness of the safeguarding plan was not adequately reviewed.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had taken steps to promote the rights of residents.

Inspectors viewed the notes of one resident. They noted that a referral had been made to the provider's human rights committee. Through this process, the resident's opinions in relation to their living arrangements and the running of the designated centre were recorded. Their choices and preferences were identified and acted upon.

Regular meetings with residents were held to enable residents to make choices about their daily activities. Inspectors viewed the record of the meetings completed in 2025. This indicated that residents' choices were respected.

Inspectors observed staff offering choices to residents throughout the inspection.

Residents were supported to exercise control on their daily life and routine. Residents told inspectors that their rights were respected in this centre.
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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Moy Services OSV-0005637

Inspection ID: MON-0046607

Date of inspection: 09/04/2025

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:
A review of incidents across the service has been completed to identify any further incidents that had not been reported and have been submitted to the regulator

The PIC will ensure that all safeguarding incidents will be reported to the regulator within the given timeframe.
In the event of the PIC being on leave, the Area Manager or the Director of Service will submit the notification.

When an incident is triaged at the bi-weekly meetings the triage note template has a prompt as to whether the incident is notifiable to the regulator, this prompt is now to be read aloud and considered for every incident.
Attached to the incident triage notes there will be a plan of the actions identified from the triage meeting, when and by whom those actions have been completed. This will ensure all actions are followed up and completed.

The PIC will highlight any issues relating to safeguarding in the monthly incident audits and will include all actions taken in response to each incident. They will ensure more details are recorded on the 'Action Planned as a result of the audit' section and record a specific timeframe for these actions to be complete. Following the audit/ review of incidents where a trend is identified the risk assessments are reviewed, updated if needed and ratings are increased accordingly.
This will be discussed at a staff team meeting to share learning and ensure improvement in the service.

In the annual report any actions will have a more detailed action plan on how the service will attain a goal identified and will have a specific timeframe identified.
When there is a safeguarding plan in place the PIC will ensure the actions recorded are

specific and time bound to ensure that progress towards the goal is measurable.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Clinical Nurse Specialist in Behaviour will give definitive guidance on what best practice is to ensure the safety of the resident. If there is a further incident in relation to the resident being supported in the plan, they will review and amend accordingly. Feedback from the residents and the team will be considered at all stages of the plan development and amendments.

The Clinical Nurse Specialist has developed a one page summary of each positive Behaviour Support plan. This will include the key points of the Risk assessment, proactive and reactive strategies and will be attached to the main body of the Positive Behaviour Support Plan which all staff sign once they have read the plan.

If an incident occurs when there is an open BSP plan where staff followed the plan, the CNS will be informed as the plan will need to be amended.
All Behaviour support plans will be presented at MDT meetings where the plan will be discussed in detail.
The Clinical Nurse Specialist will complete knowledge audits of the positive BSP with staff working in the service.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
MCL has committed to ensure that all incidents will be triaged and reported to the Regulator and the National Safeguarding and Protection Team within the correct reporting time frames.
All staff have completed the mandatory safeguarding training online and also the face to face Safeguarding training facilitated by the Designated Officer within MCL.

The Safeguarding policy has been read and signed by the PIC and the staff Team in Moy Service
As above, a review of incidents across the service has been completed to identify any further incidents that had not been reported and have been submitted to the Regulator
The PIC will highlight any issues relating to safeguarding in the monthly incident audits

and will include all actions taken in response to each incident. They will ensure more details are recorded on the 'Action Planned as a result of the audit' section and record a specific timeframe for these actions to be completed. Following the audit/ review of incidents where a trend is identified the risk assessments are reviewed, updated if needed and ratings are increased accordingly.

All residents who have an open safeguarding plan will be referred to MDT for review

A working document will be developed in respect of actions from a Safeguarding plan to be used so that as each action is completed, all members of the MDT are aware of this. This will ensure plans are worked across sectors to safeguard all.

Safeguarding Audit to be completed in each service by Designated Officer annually

When there is an open safeguarding concern, a safeguarding audit will be completed by the Designated Officer

When there is an open safeguarding concern, the Designated Officer will complete a safeguarding reflection on the concern with individual staff members and/ or the staff team.

When an incident occurs where there is an open safeguarding plan, the National Safeguarding Team will be updated/informed in writing (as well as verbally) and consideration will be given to whether the current safeguarding plan needs to be altered and added to in respect of this.

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	11/06/2025
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	11/06/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	11/06/2025

Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	11/06/2025