Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation and Monitoring of Social Care Services

Overview report of governance and safeguarding in Western Care Association designated centres for people with disabilities in March 2023

July 2023

Safer Better Care

Contents

Introduction

The Chief Inspector of Social Services in the Health Information and Quality Authority (HIQA) is the independent regulator of designated centres, including designated centres for people with disabilities. Regulation assures the public that people living in a designated centre are receiving a service that upholds their rights, meets regulations and strives to reach national standards in providing safe quality care and support. The regulatory framework promotes and protects the health, wellbeing and quality of life of people in residential care, and plays an important role in driving continual improvement so that residents have better, safer lives.

Western Care Association provides a range of different services to people with disabilities across Co. Mayo. It is a registered provider of designated centres for adults and children with disabilities. As a registered provider, Western Care Association must be fit to be the registered provider by having effective governance arrangements to ensure that people living in their services have safe and good quality support and care.

Western Care Association had a history of achieving good levels of compliance in their registered centres since commencement of regulation in 2013. However, inspectors found a significant and increasing level of non-compliance since November 2022.

In October 2022, the Chief Inspector started to receive information of concern through HIQA's Concerns Helpdesk about the deteriorating quality of service. As a result of the assessment of this information, together with an increase of statutory notifications[1] of incidents, inspectors undertook inspections of 16 centres between November 2022 and February 2023.

This inspection programme found a concerning deterioration in the levels of compliance in a range of centres. As a result of significantly poor findings, the Chief Inspector issued a notice of proposed decision to cancel the registration of one of these centres. As set out in the Health Act 2007 (as amended) (the Act), the provider had 28 days to make representation to the Chief Inspector setting out the reasons why the cancellation

[1] A statutory notification is information the provider is required to submit to the Chief Inspector. The regulations set out the type of information to be submitted and its frequency.

should not take effect. In addition, the provider was also issued with a formal warning letter in relation to the levels of non-compliance in two further centres.

Given the level of non-compliance across the centres inspected, the Chief Inspector was concerned about the capacity of the Western Care Association to monitor their own centres to ensure that residents were being provided with safe and good quality supports that they are entitled to. The Chief Inspector decided to inspect the remaining centres operated by the provider over a two-week period and to assess the overall capacity of the provider to deliver safe and good quality services to residents.

This report relates only to the Western Care Association designated residential centres registered by the Chief Inspector. The Chief Inspector does not have legal authority to regulate or assess any other services operated by Western Care Association. The report sets out the overall findings of the inspection programme undertaken since November 2022 and the outcomes of the inspections undertaken over the course of two weeks in March 2023.

Targeted regulatory programme

As of 1 March 2023, Western Care Association was operating 36 residential registered designated centres in Co. Mayo, providing 144 residential places. 16 of the centres were inspected between November 2022 and February 2023 and an inspection report was issued in relation to each of these inspections. The remaining 19 centres were inspected over a two week period in March 2023. Given the condensed nature of that programme, the findings have been incorporated into this overview report. One centre had only recently opened and subsequently was not included in the inspection programme.

During a two-week inspection programme undertaken between 13 to 21 March 2023, inspectors met with 54 residents and 74 staff members, including persons in charge. In addition, inspectors spoke with both middle and senior management in Western Care Association. This process was completed on 29 March 2023.

As part of this escalated regulatory programme, inspectors identified four key regulations to assess the overall effectiveness of Western Care Association's

governance and oversight arrangements for its designated centres in Co. Mayo. These regulations were:

- Regulation 23: Governance and Management
- Regulation 8: Protection
- Regulation 7: Positive Behavioural Support
- Regulation 26: Risk Management Procedures.

Inspectors also considered the quality of life for residents in each centre as an essential aspect of the inspection programme, and this is included in a later section in this report which is focused on the voice of the resident.

Summary of findings

Overall, inspectors found that in each residential centre, persons in charge and staff were committed to meeting the needs of residents and engaged with residents in a respectful and kind manner.

However, inspectors also found that the provider had inadequate oversight and support arrangements for persons in charge and staff. Inspectors found that this was having a negative impact on the provider's ability to deliver consistent, good quality support to people with disabilities who lived in these centres.

Inspectors found that since her appointment in November 2022, the Interim Chief Executive Officer of Western Care Association had recognised the shortcomings in the governance arrangements and was taking action to address the more immediate issues within the organisation. She was working with all levels of management and the Board of Directors to develop and implement a governance improvement programme. At the time of the March 2023 inspections, this was in a very early stage of development and its impact on the quality of the service for residents was not yet evident.

There were a number of positive findings from the inspections in March 2023. These included:

- Staff were knowledgeable about safeguarding residents and were committed

to ensuring the safety of residents. However, inspectors found that the provider was not ensuring consistent implementation of safeguarding arrangements. This is discussed later in the report under the section on Regulation 8: Protection.

- Staff were seen to be respectful of residents and to support them in a kind and caring manner.
- Western Care Association had undertaken a programme of renovation and upgrading of its premises to improve the physical environment of centres. Inspectors found that in houses that had been upgraded, residents had pleasant, homely environments that were personalised and comfortable.
- Persons in charge were suitably experienced, qualified and knowledgeable about their centres, and were committed to providing a good quality of care and support for residents.

Areas of inadequate governance and oversight that were negatively impacting on the quality of the service included:

- All risks were not being identified and mitigated
- Areas of risk which had been identified were not appropriately escalated to senior management or addressed consistently by management
- Safeguarding arrangements were not followed resulting in critical incidents not being appropriately investigated, which increased the risk of future reoccurrence. As a result opportunities for learning were missed.
- Restrictive practices impacting on the quality of life and freedoms of residents were not subject to objective review to ensure residents' rights and wellbeing were protected
- Behaviour support plans, which are developed to guide staff on how best to support residents, were not subject to regular review and there were delays in access to multi-disciplinary support
- Staff refresher training in a range of important areas that impacted on the wellbeing of residents, such as positive behaviour support training and epilepsy

training, was not provided or was subject to delays even where there was an identified risk
- There were inadequate arrangements for staff supervision, management support and out-of-hours support arrangements

Where inspectors identified risk that had an immediate impact on the quality and safety and quality of life for residents during March 2023, these were escalated to the provider during the inspection and the provider was required to take urgent action to address them. In total, the provider was required to take urgent action in six of the 19 centres that were inspected. The requirement for urgent action related to:

- Safeguarding
- Positive behaviour support
- Risk management
- Governance and management arrangements

These findings are discussed in more detail below.

Western Care Association as a registered provider

Western Care Association is the largest provider of registered designated centres for people with disabilities in Co. Mayo and is funded by the Health Service Executive under Section 39 of the Health Act 2004. As of 1 March 2023, Western Care Association directly operated 36 of the 52 designated centres for people with disabilities in Co. Mayo. These centres provided 144 of the 242 residential places available in designated centres in Co. Mayo.

The Interim Chief Executive Officer reports directly to the Board of Directors and is supported in her role by the Head of Operations. There were eight area managers who reported to the Head of Operations. There were 23 persons in charge who reported to the area manager within their geographical area. 14 persons in charge had responsibility for multiple services which were not registered by the Chief Inspector, such as individualised services and day services. The organisational structure of Western Care Association at the time of the March 2023 inspections is set out in

Appendix 2.

The following table sets out the registered residential centres directly operated by Western Care Association in Mayo at the time of the March 2023 inspection programme.

Centre ID Number	Centre Name	Registered Bed Spaces
OSV-0005648	Woodlands Residential Service	1
OSV-0005651	Greenlands Residential Service	1
OSV-0001781	Áit Ellie Residential Service	1
OSV-0003916	Slieve Rua Residential & Respite Services	12
OSV-0005604	Newlands Residential Service	1
OSV-0001752	Glade House Residential Service	3
OSV-0005717	Windmill View Residential Service	1
OSV-0001771	Lannagh View Residential Service	4
OSV-0001782	Pine Grove Residential Service	5
OSV-0001757	Lakeside Residential Services	7
OSV-0003915	St Rita's Residential Service	4
OSV-0004108	Abbey Respite & Residential Services	7
*OSV-0008464	Hillside Apartments	2
OSV-0001778	Ceol na hAbhainn Residential Service	2
OSV-0004810	The Acres Residential Service	2
OSV-0001789	Wood View Residential Service	4
OSV-0001751	Aras Aoibhinn Residential Service	4
OSV-0001770	Cherry Blossom Residential Service	1
OSV-0005782	Hillfort View Residential Service	1
OSV-0001790	Westside Residential Service	7
OSV-0001783	Forest View Apartments	3
OSV-0003702	Mountain View Residential & Respite Services	8
OSV-0003917	Cheile Creidim Respite Services	4
OSV-0003918	Abbeydeale Residential Services	7
OSV-0003914	Acorn Residential Service	10
OSV-0001756	Orchard Grove Residential Service	3
OSV-0001780	Hillcrest Apartments	3
OSV-0001772	St Stephen's Respite Service	4
OSV-0006746	Bay View Residential Service	1
OSV-0001755	Hill View Respite & Residential Services	5
OSV-0005743	Cara Service	3
OSV-0001769	Blath na hOige Residential Service	4
OSV-0005675	Rose Cottage Residential Service	1
OSV-0001773	Cois Locha Residential Service	4
OSV-0001765	Cois Fharraige Residential & Respite Services	9
OSV-0001774	St Francis Residential Service	5

*This centre was registered on 12 January 2023 and was excluded from the March 2023

targeted inspection programme as it was only newly established. It continues to be monitored by the Chief Inspector.

Inspection findings

The purpose of the intensive two week inspection programme undertaken during March 2023 was to assess the effectiveness of the provider's governance arrangements in delivering and monitoring the quality and safety of services for people with disabilities. This section of the report sets out the aggregated findings of all inspections from November 2022 to March 2023.

Regulation 23: Governance and management

Overall, inspectors found that the provider did not have consistent and effective oversight arrangements to ensure that people with disabilities were being provided with a good quality support service.

Inspectors found that there was a variance in the levels of responsibility of persons in charge and area managers, with some having a significantly greater number of services within their remit and insufficient support to effectively manage those service portfolios. 14 persons in charge were responsible for multiple services including day services and what the provider termed as 'individualised services'. In one case, a person in charge had responsibility for 17 services which significantly impacted on their ability to effectively manage the designated centres under their remit.

Inspectors found that while managers were committed to the welfare of residents, in the absence of a governance framework, each regional area had developed their own systems for oversight of centres, resulting in inconsistencies and a reliance on informal and sometimes ineffective arrangements to ensure the quality of support for residents.

Inspectors spoke with staff and managers about arrangements for their support and supervision. Persons in charge told inspectors that they had regular contact and face-to-

face meetings with their area managers. However, there was no consistent, formal supervision arrangements with set agenda items by which to structure these meetings. Inspectors reviewed supervision records for persons in charge and found that many did not include a review or monitoring of day-to-day operations of the centre or updates on improvement actions. The provider's policy required supervision meetings for all staff three times a year but the frequency of supervision for persons in charge was inconsistent. For example, in one centre inspectors saw that the person in charge had supervision every three months, in another centre the frequency was every six months, and in a third centre there had been no supervision meetings for the past four years. Inspectors found that some area managers had developed their own bespoke supervision arrangements, however these initiatives were not shared across the organisation.

Similar findings were evident in supervision arrangements between persons in charge and their staff teams. Again, often due to large service remits, supervision meetings and team meetings were not consistent. Staff support arrangements were informal, on occasions undocumented and where areas for action were identified there was little evidence that these were followed up on.

Persons in charge described how they attended team meetings with their peers and respective area managers. Inspectors reviewed a sample of records from these meetings and saw that they were attended by all managers under the area manager's remit. Persons in charge described the meetings as supportive, but said that they focused more on organisational issues rather than topics prevalent in designated residential centres. Furthermore, they did not provide opportunities for shared learning especially in areas such as behaviours of concern and safeguarding risks.

The provider had a process in place for persons in charge to undertake audits of their centres. However, inspectors found that the audits were time consuming and were not effective to inform improvements in the quality of support for residents in the centres. Inspectors reviewed the audits in each centre and found that they examined practices such as residents' individual plans, finances, medication and infection, prevention and control (IPC). However, they did not reflect the individual circumstances of each centre.

They were quantitative in focus and did not examine the quality of services being provided to residents. For example, audits of personal plans focused on the number of plans within each centre and did not examine whether they reflected the will and preferences of residents or whether they had been updated in line with recent multidisciplinary recommendations or residents' changing needs

The audits were not consistently implemented in each centre and, where they had been completed, inspectors found that they did not support quality improvement. For example, in one of the centres, a recent medication management audit had failed to identify a significant medication error which was clear to the inspector on review. Where audits had identified areas for improvement, action plans were created but were not formalised or appropriately monitored. Many of the actions reviewed by inspectors had not been completed. In one centre, an audit in May 2022 had identified maintenance works that were required. In March 2023, the actions had still not been completed and the issues continued to impact on the safety of the environment for residents.

While senior management signed off the actions from audits, there were no follow-up arrangements for senior management to confirm the implementation or the effectiveness of the actions in addressing the issues of concern or opportunities for improvement. There were also no arrangements to identify any trends across centres from audits to inform a holistic approach to quality improvement.

In compliance with regulatory governance requirements, the provider had nominated the area managers to undertake unannounced visits to each centre twice per year and produce a report on the visits. Inspectors reviewed the recent reports and found that the visits were not being undertaken consistently across areas. In addition, the area managers were not visiting all parts of each centre. In a recent unannounced visit to a centre with multiple houses, the area manager did not visit all of the houses. Inspector found fire safety issues in one of the houses that the area manager had not visited. Inspectors also noted that area managers were visiting centres within their own area of responsibility which was a missed opportunity for having a more objective unannounced visit to centres.

Like the other audits, the action plans from the twice per year visits were reviewed by senior management, however there were no arrangements by the Board for update reporting on progress, completion or effectiveness of the plans. In addition, no arrangements were in place to evaluate the outcome of all unannounced visits to identify improvement themes that would inform shared learning across other designated centres. Poor monitoring arrangements also resulted in actions not being addressed. These actions were highlighted repeatedly in subsequent unannounced visits.

As well as twice per year visits, the provider is also required under regulation to undertake an annual review of the care and support provided in each designated centre. As with other auditing arrangements, this was not consistently completed and was found to be overdue in two designated centres inspected during March 2023. Furthermore, as described previously, the Board had no arrangements in place to evaluate the findings of annual reviews of care and support across its designated centres. There were no arrangements to identify recurring themes and inform shared learning across designated centres.

The provider's oversight arrangements were failing to identify ongoing issues in other aspects of the centres. Inspectors saw records where persons in charge had identified staff training needs. However, inspectors found that a high number of staff in the majority of centres were still awaiting up-to-date refresher training in areas such as manual handling, medication management, positive behaviour support and feeding, eating, drinking and swallowing difficulties (FEDS) and the provider had failed to identify this as an issue.

The provider's oversight arrangements had not ensured that staff were provided with up to date policies to guide their practice. The regulations set out specific policies that must be available to staff and the provider is required to review and update them at least once every three years. The provider had not complied with that requirement in key policy areas that impact on the quality of support for residents such as positive behaviour support, risk management and use of restrictive practices.

The provider was ensuring that there were adequate staffing resources in designated centres which were reflective of residents' needs. Inspectors also found that staff were both knowledgeable and committed to meeting residents' needs. However, in one designated centre inspectors found that staff were required to respond to the needs of another service nearby that was not a designated centre. When this happened, staffing levels in the designated centre were reduced, impacting on the quality of support available to people with disabilities in the designated centre. The provider had failed to identify that this arrangement impacted on the quality and safety of the care and support for residents in the designated centre.

In order that staff had access to managerial support outside of office hours, the provider had developed an on call system. These arrangements were linked to the management structure of the designated centre with the first point of contact being the person in charge. In their absence, the next line manager was available all the way up to the Chief Executive Officer. Although no issues of concern were noted during the inspection programme, persons in charge were the first line of contact regardless of whether they were on duty or not and they expressed concerns about being required to be available constantly and its impact on a work-life balance.

In summary, while inspectors found that persons in charge and staff in designated centres were committed to meeting the needs of residents, the provider had poor oversight of the centres, with inadequate and inconsistent management arrangements. This in turn impacted negatively on the quality of support for persons in charge and on the ability of the provider to ensure that residents are provided with good quality support that upholds their human rights. It also meant that when things went wrong in centres, the provider did not have a way of responding in a timely and effective manner.

The provider did not have a strategic approach to quality assurance and ongoing service improvement and development. Arrangements for the support and development of staff at all levels were inadequate. Furthermore, monitoring and support arrangements provided minimal or no opportunity for shared learning which is

essential to ensure a consistent approach to providing good quality support to residents and to ensuring that the provider's systems and processes are fit for purpose.

Regulation	Judgment
Regulation 23: Governance and management	Not compliant

Regulation 7: Positive behaviour support

Providing positive support in relation to behavioural presentations by residents is a critical aspect of safeguarding. Inspectors reviewed the arrangements for positive behaviour support on the inspections and found a variance in the quality of support, with some centres having good quality positive behaviour support while others had poor quality support. Inspectors also found that where there was poor quality behaviour support, the provider had failed to identify this and failed to take corrective action.

Inspectors reviewed behaviour support plans, the use of restrictive practices and the access to multidisciplinary support, all of which underpin effective positive behaviour support.

Inspectors met residents with a range of behaviour support needs. In all cases, inspectors observed that staff responded to residents in a kind, respectful and considerate manner and residents told inspectors that they liked the staff, liked living in their centres and that they were supported to do activities that they enjoyed.

Inspectors found that in the majority of cases, residents who needed them did have a behaviour support plan to direct staff on the most appropriate way to respond to their needs. However, inspectors found that many of these were not being reviewed and updated regularly to ensure that they reflected the current support needs of residents. For example, in one centre, the behaviour support plan had not been reviewed since February 2021.

Inspectors also saw examples where residents had been waiting for an extended period to access the provider's specialist behaviour support service for assessment to

inform the development of behaviour support plans. In one centre, staff had completed the behaviour support assessment and developed a support plan themselves and the plan was not informed or validated by behaviour support specialists. In another centre, staff informed inspectors that there was a significant risk of self-injurious behaviour and there was no behaviour support plan for the residents. In another example, inspectors saw where staff had identified that a resident needed adaptations to their bedroom for safety reasons in response to their behaviour presentations but no referral had been made to the behaviour support specialists.

Inspectors found that there was inadequate oversight of the delivery of training in positive behaviour support and a lack of strategic approach to the delivery of training. They found that in centres where residents needed positive behaviour support, the provider had not ensured that all staff had received up to date training. Additionally, inspectors noted that the provider had delivered specialist training in relation to autism in some centres but other centres that had residents with similar needs had not been provided with the training, and persons in charge were not aware of when such training would be provided.

Inspectors were concerned about the provider's governance of the use of restrictive practices during the March inspection programme, as inspectors found that restrictive practices were not being regularly reviewed. Where they had been reviewed, the reviews had been undertaken in their own centre by the person in charge with no external, objective verification of the arrangements. The provider had previously operated an independent 'Rights Committee', which was responsible for objectively scrutinising restrictive practices to ensure they were the least restrictive option available and the rights of residents were upheld. However, this had ceased to operate prior to March 2023. Persons in charge and staff were unsure of when it ceased to operate, with some persons in charge saying that it had not operated since before 2021. Other persons in charge were unaware that it had ceased to operate and told inspectors that they continued to make referrals to the Rights Committee and told inspectors that they had wondered why they had not received an acknowledgement or response.

Inspectors observed a range of restrictive practices such as use of video and audio monitoring devices, locked cupboards and restricted access to parts of the premises which were being implemented based on local management decisions. Other examples that inspectors saw included restrictions on access to televisions, radios, personal computer tablets and staff were unable to provide a reason for such restrictions or identify when they had been implemented or reviewed.

In addition, the provider's policy on the use of restrictive practices was out of date and inspectors did acknowledge that it was under review at the time of the inspections in March 2023.

In summary, improvements were required at all levels of the provider's arrangements for supporting residents who had behaviours of concern. Improvements were needed to ensure timely access to multidisciplinary supports and up-to-date staff training. In addition, arrangements were needed to ensure the regular review and oversight of behaviour support plans and the use of restrictive practices in order to ensure the rights of residents were being upheld and to enhance the overall support provided to residents.

Regulation	Judgment
Regulation 7: Positive behavioural support	Non compliant

Regulation 8: Protection

The primary focus of this regulation is to assess the arrangements for protecting residents from the risk of abuse and ensuring good safeguarding arrangements are in place to minimise risk to residents. Therefore, a key focus of the March 2023 inspections was a review of the safeguarding arrangements in each of the designated centres inspected.

Overall, while the inspectors did not identify any significant instances of abuse, they did identify situations where the actions of some residents were impacting on the safety and quality of life of other residents through peer-to-peer interactions. Inspectors found that the provider was failing to ensure that their arrangements for responding to safeguarding concerns were being implemented consistently and ensuring a timely response to safeguarding residents.

During the inspection programme, inspectors reviewed all current safeguarding records, incident reports and residents' records in each of the 19 centres. They also met with staff and management and spoke about safeguarding arrangements across Western Care Association's designated centres.

Inspectors found that the provider did have a safeguarding policy to direct staff in their response to safeguarding concerns. However, inspectors saw examples in a range of centres where this policy was not being implemented. For example, not all safeguarding concerns were investigated in line with the policy and incidents were not being referred to the Chief Inspector, as required by the regulations. In addition, where safeguarding concerns had been notified, the provider had not completed a subsequent internal investigation to find out if improvement was required to their own processes to ensure effective safeguarding in the future.

Where preliminary screening and interim safeguarding plans had been developed, inspectors found an inconsistency in approach across the organisation. In some designated centres, staff were knowledgeable about the safeguarding plans and their implementation, whereas in other centres staff were not aware of the content of the safeguarding plans. In one centre, staff and management were unclear

about the supervision requirements for residents which had been identified in the safeguarding plan and were implementing them in an inconsistent manner. This increased the risk to the safety of the residents.

In addition, inspectors saw examples where the recommendations of the safeguarding plans were not being implemented in a timely manner. For example, in one centre a recommendation for psychological support had been identified in December 2021 and was not provided until May 2022.

Persons in charge described the provider's accident and incident system which they used for escalating significant safeguarding risks. The process required persons in charge to categorise safeguarding incidents, with risks rated below level three being dealt with locally and those above level three being escalated to their line manager and the designated safeguarding officer.

However, inspectors found that while the arrangements allowed for individual incidents that were rated level three or below to be managed locally, trends of frequently occurring low-level incidents that were having an impact on the wellbeing of residents were not being identified and their impact was not being escalated to senior management.

Inspectors found that there was inadequate auditing and oversight of safeguarding arrangements by the provider. This was particularly evident in safeguarding plans across a number of centres that had not been reviewed, updated or fully implemented. Furthermore, the provider had no structured arrangements for the regular review of individual safeguarding plans with persons in charge. Some centres had ad hoc arrangements based on the individual approach of different area managers.

In addition, safeguarding was not a topic for regular discussion in the organisation's management meetings, unless a critical incident had arisen. There were no formal structured opportunities to examine safeguarding themes across the organisation to assist in the development of consistent responses and improve upon measures to ensure the safety and wellbeing of residents.

Over the course of the March 2023 inspection programme, inspectors spoke with 74

staff members and found that although staff had a good understanding of what constituted a safeguarding concern, this was not reinforced by access to regular up-to-date training or implementation of the procedures put in place by the provider. Inspectors found that in the majority of designated centres, a number of staff had not received the refresher training in safeguarding required by the provider's policy to ensure their practices and knowledge was in line with current good practice.

Fundamental to the provider's safeguarding policy and arrangements was the appointment of Designated Safeguarding Officers. At the time of the March 2023 inspections, there were three Designated Safeguarding Officers employed by Western Care Association. Staff spoken with were knowledgeable about who the Designated Safeguarding Officers were and how to contact them. However, staff did not know who to contact outside of office hours if there was a significant safeguarding concern. The policy guided staff to contact the An Garda Síochána, which may not be appropriate under all circumstances.

In summary, inspectors found that although staff had a good understanding of what constituted a safeguarding concern, gaps in the provider's safeguarding arrangements increased the risk that there would not be an appropriate and timely response to safeguarding issues that may arise.

Western Care Association is required to ensure its safeguarding policies and procedures are implemented by all staff. Western Care Association is also required to ensure that persons in charge are provided with clear guidance regarding safeguarding reporting arrangements and thresholds for reporting.

Regulation	Judgment
Regulation 8: Protection	Not compliant

Regulation 26: Risk Management Procedures

The primary focus of risk management is to proactively identify, assess and mitigate against risks which may negatively impact on the safety of residents. Therefore, a key focus of the March 2023 inspections was a review of the risk management

arrangements in each of the centres.

Inspectors reviewed risk assessments, accident and incident reporting and residents' records in each of the 19 centres as well as meeting with staff and management about risk management arrangements across Western Care Association.

Over the course of the inspections, inspectors found that although the provider had arrangements in place for risk management, these were neither robust nor consistently implemented, leading to concerns about the provider's ability to protect residents from risk.

Shortly after arriving in a number of centres, inspectors identified risks to the safety of residents that had not been identified previously and consequently no actions were in place to safeguard residents against their impact. For example, in one centre, extensive building refurbishment works had commenced. The provider had failed to undertake a risk assessment on whether or not it was safe for the residents to remain in the same centre during the renovations; especially as at the time of the inspection, a large part of the premises was closed off and smoke detectors were covered due to painting, mitigating the effectiveness of the fire alarm system. In addition, the provider had not acted in response to damp and mildew being present in a utility room where food was being stored.

Inspectors also found that risks had not been identified and responded to in relation to residents' support needs. A resident in one centre had been assessed as having a risk of falling when using the shower. A referral had been made to the provider's own occupational therapy services in 2019, but at the time of inspection in March 2023, this had still not been completed. There was no evidence of follow up on the referral and the provider's audits failed to identify it as an issue. In another centre, inspectors met a resident who had been assessed as having high risk relating to feeding, eating, drinking and swallowing (FEDS). This risk was not identified in the resident's individual risk assessment or on the centre's risk register. While some staff had been provided with training, inspectors saw that other staff who supported the resident had not been provided with training in this critical area.

In another centre, inspectors were informed that residents had support needs in

relation to visual impairment and epilepsy. Again, the risks associated with these support needs had not been assessed and no appropriate arrangements were put in place to manage the risks. In addition, some of the staff who worked alone with the residents had not been provided with epilepsy training, and this had not been identified as a risk.

Inspectors reviewed the provider's audits and found that they had included the area of risk management. As outlined earlier in the report, inspectors found that the audit arrangements were ineffective in identifying for the provider where risks were not being managed appropriately. The audits reviewed by inspectors had not identified the absence of up-to-date fire evacuation plans for residents or that residents' personal plans did not reflect the significantly changing needs of residents. In another example, an audit of risk in one designated centre had not identified that risk assessments had not been reviewed since 2021. In another centre, the safety statement referred to managing the risks associated with residents' use of wheelchairs, although no residents currently living at the centre were wheelchair users.

Persons in charge spoke about their confusion with the provider's risk management arrangements and the absence of relevant training to provide clarity. This situation had led some managers to develop their own risk registers or to operate two risk processes (the provider's electronic system and a paper version) further creating the potential for risks to be missed.

As with incidents of safeguarding and behaviours of concerns, there were issues with consistency in the risk rating of accidents and incidents across centres. In particular, there were concerns that accidents and incidents which were risk rated below level 3 on the scale missed the impact of the frequency or intensity of repeated incidents and accidents.

In summary, inspectors found significant shortcomings in the effective and consistent management of risk by the provider across their centres.

Regulation	Judgment
Regulation 26: Risk management procedures	Not compliant

Residents' lived experiences

Spending time with residents, hearing what they have to say and observing their day-to-day life in the centre is a critical aspect of every inspection. In addition to the inspections between November 2022 and February 2023, inspectors also met with 54 residents during the March 2023 inspections. Overall, residents told inspectors that they were happy in their homes, were happy with staff and with the service that they received. In addition, most residents said that they liked their homes and that they felt safe.

Residents interacted with inspectors on their own terms, and some residents were happy to speak with inspectors and talk about their lives and what it was like to live in the centre. Inspectors also observed the day-to-day life of many residents during these inspections.

While most residents said they were happy and inspectors could see staff supporting them to do interesting things during the day, inspectors also saw where inadequate governance arrangements impacted on the quality of care and support provided to residents.

Inspectors found that risk management arrangements were not effective in identifying risks which impacted on residents' well-being. For example, the presence of mould and the impact of building renovation works which had commenced in February 2023 in one centre and the safety of residents, as discussed earlier in the report.

In some centres, inspectors saw that delays in access to regular reviews by occupational and behavioural therapists was impacting on the quality of life for those residents. As mentioned earlier in the report, one resident had been waiting since 2019 for an occupational therapy review following a fall in the shower. In another centre, referrals had not been made to behavioural services even though a resident's behaviours of concern required adaptations to their environment due to associated risks.

Inspectors saw where restrictive practices were being used that impacted on the rights and freedom of residents. Inspectors saw that some residents were not allowed access

to parts of their home and, in another example, a resident's privacy was significantly compromised by the use of video and audio surveillance devices in the resident's bedroom. These arrangements had not been reviewed by the provider since 2019.

Inspectors saw where the provider had improved the home environment for residents in a number of centres and inspectors saw that these residents were comfortable and had personalised their homes. Inspectors also observed current renovations being undertaken in other centres to ensure they meet residents' current and future needs.

Throughout the course of the 19 inspections in March 2023, inspectors met residents who were coming and going to various community activities and appointments, such as shopping trips, visiting cafes and going for drives. A number of residents attended day services external to the centre and residents told inspectors that they enjoyed this. Where residents had chosen to not attend formal day services offered by the provider, it was clear that resources had been put in place to develop a personalised option. These personalised services were staffed in accordance with residents' needs and reflected their likes, interests, preferences and goals. Inspectors could see that residents were enjoying these activities.

Residents were supported to maintain contact with friends and family either through visits as well as through access to telephones and their own personal computer tablets. There was evidence that residents' families were consulted with in line with residents' wishes.

In summary, inspectors found that residents were generally content and comfortable in their homes, and that their care needs and choices were being responded to and respected by staff working in each centre. However, governance and management arrangements were not effective which was impacting on the quality, consistency and sustainability of support and care for residents.

Conclusion

Since October 2022, the Chief Inspector received an increase in both solicited and unsolicited information which resulted in concerns about the governance and management of Western Care Association and their designated centres across Co. Mayo.

Findings of the 16 inspections conducted from November 2022 to February 2023 reinforced many of the concerns and subsequently resulted in escalated action being instigated by the Chief Inspector to ensure the wellbeing and safety of residents. Due to the outcome of the these inspections and growing concerns over the effectiveness of governance within Western Care Association, an escalated programme of inspection was undertaken to follow-up on governance, safeguarding, behaviour support and risk management arrangements in 19 centres, which was completed in March 2023.

The subsequent programme of inspections in March 2023 made similar findings, particularly in relation to the governance and oversight of centres, as those in the previous inspections. Feedback was verbally given at the end of each inspection during the March inspections to the person in charge and management.

Overall, inspectors found that residents lived in pleasant and homely environments, which were managed by experienced and knowledgeable persons in charge, with supports from kind and committed staff teams.

However, inspectors also found that there was a heavy reliance on individual persons in charge to report issues, with inadequate systems to support persons in charge and ensure accountability for the quality of support being provided to residents. This led to inconsistencies in the management of centres and significantly increased the risk of safeguarding or other issues arising and not being identified and responded to in a timely manner.

Inspectors found that the provider had poor arrangements in place to monitor its centres and risk management arrangements including those associated with safeguarding and behavioural support were inadequate.

As a result of the findings from this inspection programme, the Chief Inspector is

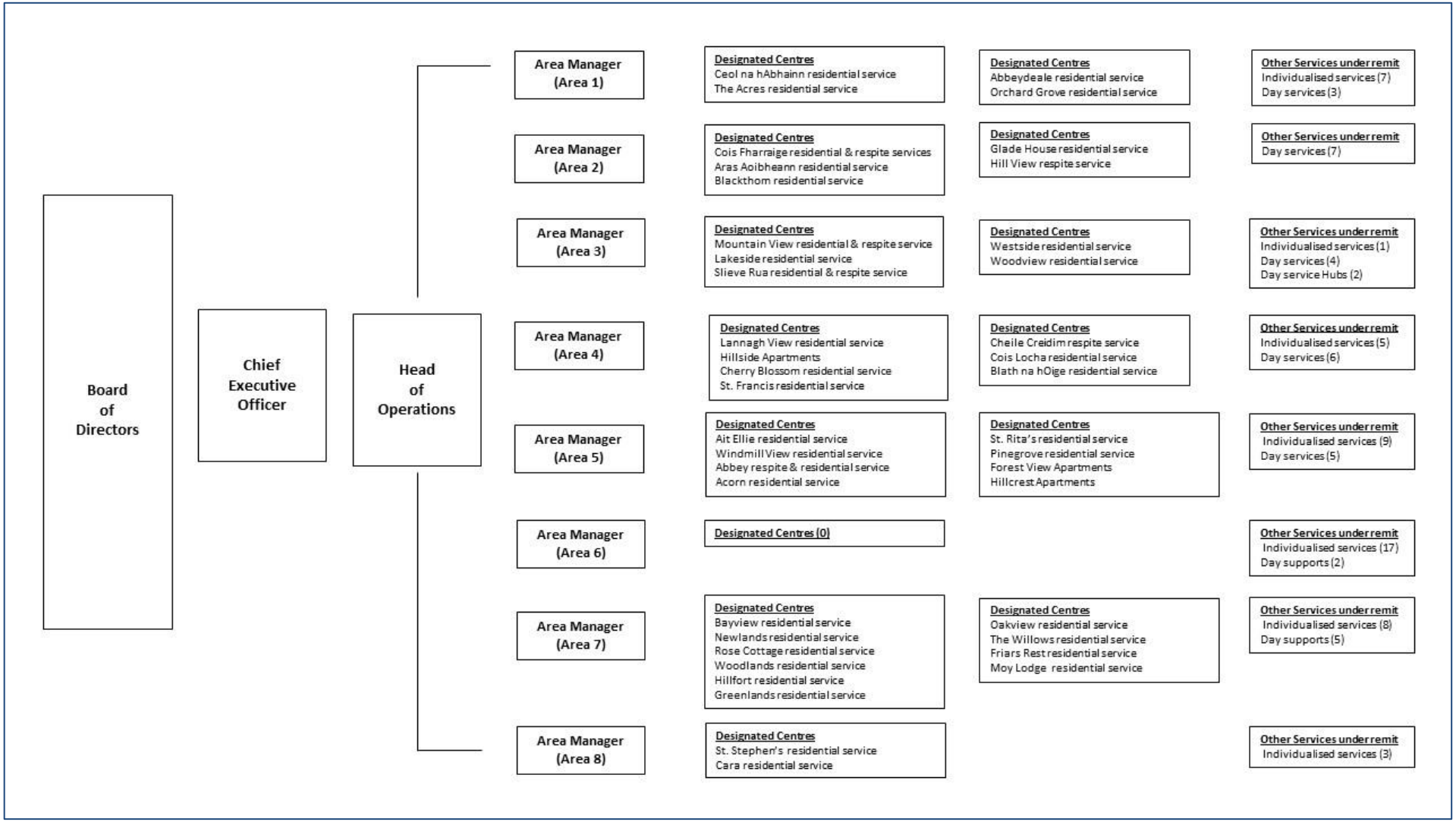
requiring Western Care Association to implement a governance improvement plan that results in improvements in the safety and the quality of life of residents across their residential designated centres. Inspectors will monitor and inspect the implementation of this plan in a planned programme of inspection over the next twelve months to verify whether the actions of the provider are effective in upholding the rights of residents.

Appendix 1 – Regulations inspected under this programme

The inspections that were carried out under this programme assessed 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. The table below shows the aggregated compliance rating:

Regulation	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 26: Risk management procedures	Not compliant

Appendix 2 – Organisation structure of Western Care Association



Western Care Association response and compliance plan

This section outlines Western Care Association's response to the report and the actions they have taken and intend to take.

Compliance Plan in response to the Overview report on designated centres for people with disabilities operated by Western Care Association – March 2023

Regulation Heading	Judgement
Regulation 23: Governance and management	**Not Compliant**

The provider has assessed the structure of the senior management team and recently appointed a Head of Quality, Safety and Service Improvement, an Interim Head of Clinical and Community Supports and a Head of Properties and Facilities to ensure a clearly defined governance arrangement for consistent and effective oversight for distinct aspects of service delivery. This team is led by the Interim Chief Executive Officer with representation from clinical and community supports, operations, safeguarding and protection, human resources, finance, properties and facilities and quality, safety and service improvement.

The senior operations team structure has been assessed and reconfigured into eight service areas to ensure equitable and consistent governance, management and oversight of defined service locations. This team is led by the Head of Operations.

An assessment of the frontline management structure has commenced to ensure equitable and effective operational management of each designated centre. This assessment will include discussion and consultation with all key stakeholders on models of service, staffing resources and on-call arrangements to ensure quality and safety of support and care provided. This assessment will be completed by the 30/09/2023.

An independent HSE Service Improvement Review has commenced and a Service

Improvement Oversight Committee has been established as that of the review to support the Provider through the functions the CEO and Senior Management Team to maintain effective oversight on the delivery of services and the delivery of priorities within the organisation. A key aspect of the Service Improvement and Oversight Committee is to identify good practice and performance whilst also recognising areas of development and improvement to inform organisational planning and change. A service improvement framework will be formatted as part of this review and six work streams have been established. These workstreams include, Leadership Governance and Management, Service Models and Quality, Safety and Safeguarding, Human Resources, Finances and Resident and Staff Consultation. This review is independently chaired and each workstream's membership consists of representatives from the organisation, HSE and external professionals.

An independent Quality Assurance review has been completed, which measured and evidenced the quality of the service provision to individuals accessing the services. The review examined organisational structures, systems and care practices and the provider is considering its recommendations to ensure that services provided are safe, appropriate to each resident's needs, consistent and effectively monitored to ensure quality of supports. The recommendations from this review will form part of the provider's governance and quality improvement framework.

The Head of Quality, Safety and Service Improvement will devise a governance and quality improvement framework. The framework will be aligned to the service improvement framework and address recommendations from the independent Service Improvement and Oversight Committee, quality assurance review, regulatory findings and will be underpinned by legislative requirements, national standards, and best practice approaches. The framework will identify and monitor key processes, practices, audits and systems in order to identify patterns and trends to result in organisational learning, quality assurance and improvement. The implementation of this framework will commence by 30/09/2023, and will be subject to monthly monitoring or as required.

As part of this framework the revised Quality, Safety and Service Improvement

department will review the current suite of audits to ensure,

- There is a standardised audit tool and smart action plan
- Support auditor to populate the audit tool with qualitative data
- Each audit has a specified timeframe for completion

As appropriate these audits will prompt the auditor to assess restrictive practice, rights, resident's will and preferences and to ensure that relevant individual assessments, personal plans, personal risk management plans and behaviour support plans are updated to reflect changes in needs and circumstances. A systematic approach to auditing and associated actions will be implemented using a technical solution to ensure organisation wide learning.

Members of the senior management team along with a member of the senior or frontline operational management team will undertake objective bi-annual unannounced visits to each designated centre from July to December 2023. The bi-annual unannounced visit template will include a review of audits in the previous six months. The provider will designate the responsibility for the completion of the unannounced visits and the annual reviews of the quality and safety of care and support to ensure independence in relation to the process and to inform practice and decision making at senior management level. The annual review will provide for consultation with residents and their representatives and that a copy of the review will be available to them.

On completion of these visits and reviews, a bi-annual thematic governance and quality improvement report will be presented to the Provider, Senior and Operational Management Teams in July 2023 and January 2024. The objective of this process is to ensure that from the findings strategic and operational plans result in positive outcomes for residents and continuous governance and quality improvements.

The provider is currently reviewing its staff training and development system and training needs analysis for staff in each designated centre and the organisation. On completion the provider will ensure oversight through the implementation of a smart

action plan to monitor and evaluate the staff training and development programme. (31/10/2023)

Monthly staff regulatory events are scheduled for the remainder of 2023. These events are delivered by the Head of Operations to ensure staff are informed of the Health Act 2007, the 2013 Care and Support Regulations and National Standards for Residential Services for Children and Adults with Disabilities.

In 2023, the provider reviewed all its Policies and Procedures which are available on the organisation's intranet. The schedule 5 policies are also available in hard copy format in each designated centre. The Quality, Safety and Service Improvement department will ensure that a review mechanism is in place so that each policy and procedure is reviewed at a minimum within a three-year cycle and/or in response to legislative changes, review or regulatory recommendations/findings and best practice.

The Quality, Safety and Service Improvement department is reviewing and updating a number of policies such as, staff support and supervision, listening and responding to people, restrictive practice, risk management and incident management policies. All staff will be inducted to the revised policies. In addition, the provider will ensure its safeguarding policy is reviewed in adherence to updates in the national safeguarding policy in July 2023.

The Incident Monitoring and Oversight Committee was re-established in April 2023 and is currently chaired by the Head of Operations. The committee meets quarterly to monitor and review incident identification, recording, investigation and learning from, serious incidents or adverse events involving residents and will ensure that appropriate action and shared learning takes place.

An independent Chairperson has been appointed to the Human Rights Committee which will be re-established by 31/07/2023. In the interim, all rights restriction checklists are submitted to the Interim Chief Executive Officer for review. The Committee will meet on a monthly basis to ensure independent and transparent

oversight with respect to each person's autonomy and the identification and on-going monitoring of rights restrictions in line with the provider's policy and best practice. The committee will also review the quarterly notifications as per regulation 31 (3) to ensure external, objective verification of arrangements in place.

The provider will continue to implement its Properties and Maintenance Plan with regard to existing properties and on acquisition of new properties. The plan will be monitored by the Properties and Facilities Manager who will report quarterly to the management team on progress.

The organisation has agreed to implement a standardised meeting agenda template across all senior and frontline management levels which includes the following permanent agenda items,

- Safeguarding,
- Incident Management,
- Risk Management
- Quality Improvement.

The organisation is planning events between September and December 2023 for all management levels to provide an opportunity for shared learning and connectivity.

The interim Chief Executive Officer and Head of Operations meet with the advocates on a regular basis to listen to their feedback, lived experience and to share organisational updates.

A standardised monthly reporting template will be devised to ensure the Provider is appraised of organisational updates related to clinical and community supports, operations, safeguarding and protection, human resources, finances, properties and facilities and quality, safety and service improvement. (31/08/2023)

The Provider remains in active engagement with the commissioner of services and has submitted a business case inclusive of the requirement of a costed workforce plan.

Regulation Heading	Judgement
Regulation 7: Positive Behaviour Support	**Not Compliant**

The provider has appointed an interim Head of Clinical and Community Supports. This role reports directly to the Chief Executive Officer and is a member of the senior management team. This role holds oversight and accountability for all clinicians inclusive of the Psychology and the Behaviour Support team. This role will also enhance the management and leadership structure for all clinicians, and work closely with the operational management structure.

The Provider recognises that those staff directly supporting residents with Intellectual Disabilities and Autism require support, guidance and advice from a range of clinicians, and therefore has employed a number of additional practitioners such as Assistant Psychologists and Behaviour Support Specialists.

Under the leadership of the Psychology team, Governance and Clinical Oversight groups have been established as and when required to ensure a coordinated and comprehensive response when the level and severity of behaviour incidents is such that it challenges the security and continuity of the resident's placement or significantly impacts the resident or others wellbeing and quality of life. The Psychology team will lead in the commencement of a review of this process to ensure there is consistency in organisational practice and associated documentation. (31/08/2023)

Since February 2023, the Psychology Service has led the development of a series of one day training sessions for support staff working with people with autism. To date four sessions have been delivered, providing training to approximately 80 members of staff.

The provider will ensure,

- The Psychology team will develop a two-day core mandatory training module on neurodiversity, in consultation with the Staff Training and Development

Manager, the Senior Operational Team and an external trainer. (31/10/2023)

- That all frontline staff will undertake the two days neurodiversity training as part of the staff induction programme.
- A planned schedule of this training will be delivered to existing staff between November 2023 and June 2024.
- On an on-going basis, all staff will receive refresher training in line with current practice as requirement arises.
- All staff will receive refresher neurodiversity training every three years.
- The neurodiversity training will be reviewed annually and updated in line with best practice by the psychology team and in consultation with the staff training and development department.

The Psychology team will establish a Behaviour Support Plan Governance and Oversight Committee, inclusive of committee purpose, functions, membership, procedures and process. (31/08/2023)

Key functions of the committee will include,

- Maintaining a record of all behaviour support plans in place.
- Undertaking audits on current behaviour support plan practices and oversight to ensure correlation with organisational policy and best practice.
- Critically reviewing each resident's behaviour plan to ensure every effort is made to identify and alleviate the cause of the resident's behaviour of concern.
- Ensuring all alternative measures are considered before a restrictive practice is used.
- Critically monitoring each plan to identify opportunities for systematic learning and development.
- Utilising the data from this monitoring to consider effectiveness, to clarify best local practice, organisational policy and to identify quality improvement.
- Completion of a bi-annual report to the Senior Management team to form part of the bi annual thematic governance and quality improvement report which will be presented to the Provider, Senior and Operational Management Teams.

The psychology team will lead the review and update of the listening and responding

to people policy (31/10/2023) which will include,

- The Behaviour Support Plan Governance and Oversight Committee's purpose, functions, membership, procedures and process. (31/08/2023)
- Behaviour Support Plan template and the process for the review of the behaviour support plan. (29/09/2023)
- Updated guidance on the referral process to the Psychology Team for behaviour support.
- Updated guidance on the referrals to the Psychology Service will be disseminated to all staff which clearly outline the process for making a referral to the psychology team for behaviour support. (23/06/2023)

The Interim Head of Clinical and Community Supports will commence a review of the roles and functions of the Psychology Team and develop an inter-clinical team working policy, to include governance and oversight procedures. (31/10/2023)

The Incident Monitoring and Oversight Committee was re-established in April 2023 and is currently chaired by the Head of Operations. The committee meets quarterly to monitor and review incident identification, recording, investigation and learning from, serious incidents or adverse events involving residents and will ensure that appropriate action and shared learning takes place.

An independent Chairperson has been appointed to the Human Rights Committee which will be re-established by 31/07/2023. In the interim, all rights restriction checklists are submitted to the Interim Chief Executive Officer for review. The Committee will meet on a monthly basis to ensure independent and transparent oversight with respect to each person's autonomy and the identification and on-going monitoring of rights restrictions in line with the provider's policy and best practice. The committee will also review the quarterly notifications as per regulation 31 (3) to ensure external, objective verification of arrangements in place.

Regulation Heading	Judgement
Regulation 8: Protection	**Not Compliant**

As per the provider's current safeguarding policy, all staff will be informed of their responsibility with regard to safeguarding reporting arrangements, thresholds for reporting and the steps to take when an issue of concern is observed or brought to their attention out of hours.

The provider has a visual descriptor of all named designated officers and their contact details in visible locations throughout the organisation's service location.

The Provider will complete an internal investigation as may be required following the notification of a concern to determine if improvements may be required to organisation process and/or practice.

The provider will ensure that arrangements for responding to safeguarding concerns are consistently implemented across all service locations in a timely manner to ensure safeguarding of all residents and that the regulator is notified as required under regulation 31.

Where a safeguarding plan has been implemented, the Person in Charge and/or Area Manager will ensure all staff are fully aware of the contents of the plan and ensure that recommendations made are adhered to in a timely manner.

In addition to the HSE online safeguarding training, the safeguarding training module has been reviewed and is actively being delivered through face to face learning events by trained designated officers employed by the provider.

The Head of Clinical and Community Supports will continue to ensure that all safeguarding plans will be subject to six monthly reviews or sooner if required with the Person in Charge and/or Area Manager.

The Interim Head of Clinical and Community Supports will establish a safeguarding oversight committee by the 31/10/2023 to ensure there is a robust system for reviewing all safeguarding concerns. This committee will,

- Maintain a record of all open safeguarding plans in place.
- Undertake audits on current safeguarding practices and oversight to ensure correlation with organisational policy and best practice.
- Critically examine safeguarding themes across the organisation
- Review all internal investigations to determine where improvement may be required to the process to ensure effective safeguarding processes are in place to ensure the safety and wellbeing of residents.
- Ensure that all staff are knowledgeable in relation to the contents, recommendations and implementation of all active safeguarding plans.
- Review and update safeguarding policy as and when required.
- Complete a bi-annual report to the Senior Management team to form part of the bi annual thematic governance and quality improvement report which will be presented to the Provider, Senior and Operational Management Teams.

The organisation has agreed to implement a standardised meeting agenda template across all senior and frontline management levels which includes safeguarding as a permanent agenda item.

The Interim Head of Clinical and Community Supports in consultation with the designated officers will ensure the organisation's safeguarding policy and procedures will be reviewed and updated to reflect amendments to The National Safeguarding Vulnerable Persons at Risk of Abuse Policy and Procedures in July 2023. This will incorporate new enhanced practices and the development and implementation of a new Preliminary Screening form. The policy will also include the organisation's Safeguarding Oversight Committee's purpose, functions, membership, procedures and process.

The Incident Monitoring and Oversight Committee was re-established in April 2023 and is currently chaired by the Head of Operations. The committee meets quarterly

to monitor and review incident identification, recording, investigation and learning from, serious incidents or adverse events involving residents and will ensure that appropriate action and shared learning takes place.

Regulation Heading	Judgement
Regulation 26: Risk management procedures	**Not Compliant**

The Incident Monitoring and Oversight Committee was re-established in April 2023 and is currently chaired by the Head of Operations. The committee meets every two months to monitor and review incident identification, recording, investigation and learning from, serious incidents or adverse events involving residents and to ensure that appropriate action and shared learning takes place.

The Incident Monitoring and Oversight Committee will lead in the review of the organisation's incident injury policy and process to ensure,

- Robust identification, assessment, mitigation and categorisation of risk including scoring and escalation of risks.
- Oversight of all categories of incidents including those with a severity rating of level 1 and 2.

Quarterly incident data reports will be collected and analysed by the Incident Monitoring and Oversight Committee and communicated to the Person in Charge, Area Manager, Operational and Senior Management level and the Provider. (30/06/2023)

An incident management training module will be developed in consultation between the Head of Quality, Safety and Service Improvement, Staff Training and Development Manager and the Senior Operational Team for staff at all levels following the review of the incident injury policy and process to ensure consistent implementation of the policy and associated incident management practices. (31/10/2023)

There will be a review of the risk management policy and process to ensure,

- Clarity on the process of identifying, recording, investigating, and learning from risks involving residents and risks identified in the centre.
- Standardisation of the organisation's risk assessment and risk register format and system of use.
- Alignment of centre risk assessments to the centre's risk register.
- Alignment of the personal risk management plan with the centre's risk register.
- The escalation process of risks to operational and senior management level.
- The system for responding to emergencies.
- A risk management training module will be developed in consultation between the Head of Quality, Safety and Service Improvement, Staff Training and Development Manager and the Senior Operational Team for staff at all levels following the review of the risk management policy and process to ensure consistent implementation of the policy and associated risk management practices. (31/10/2023)

As part of this framework the Quality, Safety and Service Improvement department will review the current suite of audits to ensure,

- There is a standardised audit tool and smart action plan
- Support auditor to populate the audit tool with qualitative data
- Each audit has a specified timeframe for completion

As appropriate these audits will prompt the auditor to assess restrictive practice, rights, resident's will and preferences and to ensure that relevant individual assessments, personal plans, personal risk management plans and behaviour support plans are updated to reflect changes in needs and circumstances. A systematic approach to auditing and associated actions will be implemented using a technical solution to ensure organisation wide learning.

The organisation has agreed to implement a standardised meeting agenda template across all senior and frontline management levels which includes incident and risk management as permanent agenda items.

Section 2:

Regulations to be complied with

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

Regulation	Judgment	Date to be complied with
Regulation 23	Non Compliant	31/01/2024
Regulation 07	Non Compliant	30/06/2024
Regulation 08	Non Compliant	31/10/2023
Regulation 26	Non Compliant	31/10/2023

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