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:	Hazelwood
Name of provider:	Health Service Executive
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	09 June 2025
Centre ID:	OSV-0003321
Fieldwork ID:	MON-0047000

About the designated centre

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

Hazelwood is a designated centre which provides residential services on a campus based setting in County Mayo. The centre supports residents who have an intellectual disability and who may also have complex medical needs and reduced mobility. This centre can accommodate eight male and female adults and the service is closed to any further admissions apart from residents who may be currently residing on the campus. There is 24 hour nursing care offered in this centre and residents are also supported by health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Monday 9 June 2025	13:00hrs to 20:00hrs	Mary McCann	Lead

What residents told us and what inspectors observed

Hazelwood designated centre consists of three houses and is registered to provide care to eight residents. There were seven residents living in the centre on the day of inspection. The inspector visited one house that was the home of three residents. Two residents were available in the centre when the inspector arrived and one resident was availing of a day service in a local town. This was an unannounced risk inspection which focused on one house in the centre. On arrival the front door was locked but was opened promptly. The inspector spoke with staff and explained the purpose of the inspection to the staff member who welcomed them into the centre. An area manager arrived some 10 minutes later and assisted the staff member to find documentation.

The inspector found that this centre had good procedures in place to safeguard residents. The inspector observed practices, interaction of residents with staff and other residents, met with all residents, two staff and two area managers and reviewed relevant documentation to form judgments on the quality and safety of the care and support provided to residents. The quality of this service delivered to residents was enhanced by the provider ensuring that adequate resources were available to ensure the care and welfare of residents was prioritised and protected. This also ensured that residents' rights to engage in meaningful activities was protected. An established staff team was available which was crucial to ensuring continuity of care in this service due to the assessed needs of residents. Staff were observed to preparing lunch for residents which was cooked by staff on site. Staff assisted the two residents with their nutritional intake and were aware of the residents care plans to ensure safe feeding.

The inspector reviewed the staffing roster from the 20 April 2025 to the 2nd June 2025, notifications regarding safeguarding that were submitted to the Chief Inspector since the January 2025 and staff training records. The area manager stated that as part of the quality improvement plan for this centre all staff would have completed human rights training by the end of the year. The inspector engaged with all three residents. Two residents due to their health needs had a nap in the afternoon. One had recently had a significant birthday and seemed delighted to point to the decorations and cards from their birthday. Staff on duty confirmed that these two residents required assistance to express their views. The other resident could speak freely. As part of this inspection, the inspector spent time in the company of residents and observed the care and support interactions between residents and staff at intervals throughout the day.

When the resident returned from the day services they requested to go clothes shopping with staff, which staff facilitated. They were delighted to show the inspector their purchases when they arrived back at the centre. This resident had recently moved into the centre and told the inspector they had settled in well, got on with the other residents, staff were kind and caring to them and they were very happy and got to do the things they wanted to do and felt supported by staff. They

stated they showed the inspector their bedroom which was clean, tidy and personalised. The resident confirmed that if they had any complaints or safeguarding concerns they could speak to any of the staff and felt they would help them. The centre consists of three bungalows and the inspector visited one of the bungalows, Lough Conn House. The sitting area was open plan and while staff had tried to make it cosy it wasn't homely in nature. There are plan in place to relocate to a new premises. While to centre was clean and odour free there wasn't good light. Each resident had their own bedroom which was personalised. A utility room was provided for the storage of cleaning items. There was a small garden area to the front of the building and no garden to the back but the centre was located beside the two other houses who formed the designated centre and there was area which residents could walk between houses.

Capacity and capability

There was good governance in this centre. These included an overall quality improvement plan where any areas for improvement from audits, six monthly unannounced visits and annual reviews were documented and an action plan devised to address these deficits. Staffing numbers and skill-mix were suitable to meet the assessed needs of residents and staff had up-to-date training relevant to the needs of residents. An out of hours on call service was provided management to support staff in the absence of the person in charge and staff were aware of the details of this service. Regular staff meetings occurred and residents' needs were discussed at these meetings. This assisted with ensuring consisting in the delivery of care to residents. Minutes were available of these meeting so that staff who were unable to attend could update themselves of the discussion at these meetings.

Regulation 15: Staffing

The inspector reviewed the rosters from the 20 April 2025 to the 2nd June 2025 and found that there was adequate staff on duty to meet the needs of resident. During the day from 08:00 to 20:00 hrs there were three staff on duty.This meant that residents could engage in individual activities. From 20:00 hrs to 08:00 hrs there were 1.5 staff on duty. This house shared a night staff with another house which was part of the designated centre. While some agency staff were employed there had worked on a long term basis in the centre and knew the residents well.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector found that staff had completed training in safe nutritional care, safeguarding, fire safe, behaviour management and safe management of epilepsy. Records indicated that staff had undertaken training in safeguarding, positive behaviour support and fire safety. Other training to include nutritional care had also been completed. This meant that staff had up-to-date knowledge on how to support residents to meet their needs. A wheelchair accessible minibus was available exclusively to this centre to support residents to attend day services as they wished and activities of their choice.

Judgment: Compliant

Regulation 23: Governance and management

The provider had effective systems in place to ensure there was good oversight of the governance and management in this centre. The inspector reviewed the most recent annual review dated January 2025. While there was an easy to read version available of this, there was no evidence in the annual review of consultation with families or residents as required by regulation 23 .Governance and management. . The annual report gave a good overview of the service and an action plan was developed where improvements were required, for example ensuring all staff training was up to date.

The provider also completed unannounced audits of the service every six months. The previous two had been completed in May and December 2024. The inspector reviewed the Dec 2024 audit report and found that this was completed by an area manager independent of the centre. A schedule of audits was in place. One of the designated completed a comprehensive audit of the knowledge of staff of safeguarding. This looks at the knowledge of staff regarding safeguarding and the processes and procedures in place to report a safeguarding incident. The last audit had been completed on the 14/04/2025. Other audits completed included use of PRN (as required) medication, fire safety, and accident and incident audits. All reviews where required were accompanied by an action plan to address deficits and improve the service where a named person was identified to address these within a specific time frame.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

A contract detailing the terms on which the resident shall reside in the centre was in place for each resident. This agreement detailed the services to be provided and the fees to be charged. This meant that the resident and their representative was aware of what care and support was to be delivered to the resident and the fees the resident was responsible for.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed the accident and incident records from January 2025 and cross referenced these with the notifications submitted to the Chief Inspector and found that all notifications as required by the regulations had been submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

An effective complaints procedure in place. There were no complaints being investigated at the time of the inspection. A centre specific complaints policy was in place. This was accompanied by an easy to read version also.This ensured that if a resident wished to make a complaint they could do so. The inspector noted the complaints procedure contains an appeal process.This meant that if any person made a complaint and were not happy with the outcome they could appeal this decision

Judgment: Compliant

Quality and safety

There was generally a good service provided to residents but some improvements were required which included, improvement in the premises, care planning and ensuring goals were identified and progression of goals was recorded. While the care plans for the two residents who had been in the centre for a substantial period of time were well maintained the care planning for the resident who has recently moved into the centre requires review . This is discussed further under regulation 5. Also Clarity around recording goals and ensuring goals identified clearly show the voice of the resident also required review. Residents' safety was promoted in this

centre through good risk management procedures and clear guidance to staff. Residents health health care needs were identified and residents received good support to ensure that they maintained good health through access to a wide variety of health care professionals. Residents were kept safe in the centre. Staff were knowledgeable on how to support residents to manage their behaviour. Safeguarding plans were devised and implemented to protect residents from abuse. Risk assessments were comprehensive and identified good control measures to reduce risk to residents. There was clear information available if residents were to be admitted to hospital with good communication passports. The area manager confirmed that if a resident needed to go to hospital or was admitted to hospital, they would be supported by staff of the centre.

Regulation 17: Premises

The centre consists of three bungalows and the inspector visited one of these bungalows, Lough Conn house. The sitting area was open plan and while staff had tried to make it cosy it wasn't homely in nature. There is a plan in place to relocate to new premises. There were two bathrooms available in close location to the bedrooms which assisted in supporting the privacy and dignity of residents . While to centre was clean and odour free there wasn't good light. Each resident had their own bedroom which was personalised. A utility room was provided for the storage of cleaning items. There was a small garden area to the front of the building and no garden to the back but the centre was located beside the two other houses who formed the designated centre and there was area which residents could walk between houses.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

One resident had moved into this centre approximately two months ago and told the inspector that she had settled well into this centre and liked living in this house. She said she got on well with the other two residents and staff were kind and caring to her. They continued to attend the day service she had previously attended and was happy about this. The area managed explained that staff from the centre that the resident had moved from had attended Hazelwood to work with the resident for the last 8 weeks. The resident had visited the centre and spend time with the residents of lough Conn house prior to moving in. The centre transport supported this resident to attend medical appointments, social activities and day services. No impact assessment had been completed for the two residents who lived in Lough Conn prior to the new resident being admitted. An easy to read guide was available to these

two residents explaining that a new resident was going to be admitted. An east to read guide was also available for the resident who was moving into the centre.While the resident who moved into the centre had been refereed to advocacy services there was no evidence available that this resident had been seen by advocacy services.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management systems were in place to identify and mitigate risks to residents. There were systems in place in the centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. The staffing levels agreed by the provider also contributed to the safety of residents. Risk management arrangements in place at the centre ensured that risks were identified, acted upon to safeguarded residents from harm. The inspector spoke with the person in charge regarding the risk register. On reviewing the register the inspector found that risks were identified with controls in place to mitigate the risks. A risk management policy was also in place to assist staff in the management of risk in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed two residents' personal plans. In one personal plan these provided a good assessment of resident's needs and annual reviews were occurring, but there was poor evidence of maximum participation of the resident and recording of the decision making process as to how goals for the resident was identified. There was some evidence of the progression of the goals. In the other personal plan reviewed no goals were identified as yet for this year. The documentation was disjointed and was poorly maintained. This personal plan related to the resident who had been admitted approximately two months ago. There was evidence that the resident had developed problems with her dentures which was impacting on their nutritional care plan, however the specialist advice of the dental service and the speech and language therapist had not been implemented into the care plan to provide staff with the most up to date direction as to how to provide nutritional care safely.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector reviewed the health care records of two residents and found there good access to a range of health and social care specialist advice. Health assessments were completed and records of attendance at health and social care staff was recorded and the rationale for same was documented. Regular blood analysis was completed by the general practitioner. Each resident had a comprehensive annual medical completed by their general practitioner. Residents were facilitated and supported to avail of health screening programmes appropriate to their age; for example, breast screening or bowel screening.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was one behaviour support plan in place at the time of this inspection this was reviewed by the inspector. This had been last reviewed by the behaviour specialist on the 13 May 2025. The area manager stated that there was very good timely access to specialist behaviour support services. This plan clearly outlined what do to support the resident to manage their behaviour. Staff were recording antecedent behaviour and were aware of the behaviour support plan. Restrictive practices were in place in the centre generally related to medical issues for example a restriction on fluid intake, and bed alarms for residents who were at risk of falling.all restrictive practices are reviewed by the human rights committee annually. residents attend these meeting accompanied by staff.

Judgment: Compliant

Regulation 8: Protection

Safeguarding was well managed in this centre .There were two active safeguarding plans in place at the time of this inspection and staff were aware of these plans. There was good evidence of discussion of these plans with staff at staff meetings. All staff working in the centre had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. A policy on safeguarding residents was available which all staff had read. Details of the designated officers were displayed in the centre. The provider had ensured that all staff had Garda Síochána vetting in place prior to commencement of employment.

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	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hazelwood OSV-0003321

Inspection ID: MON-0047000

Date of inspection: 09/06/2025

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A plan is in place to improve the living environment in this house and to make it feel more homely by the addition of personalised items, positioning of furnishings and the addition of plants and soft furnishings. This will include a review of the lighting in the shared living areas of this home to maximise natural light and include additional lighting in the living room.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: A detailed audit of the Individual Assessments and Personal Plans is underway with completion date of 31/8/2025.A working group is being established to look at goal setting ensuring the voice of the resident is central to all goals across the service. A monthly review of goals and the progression and development of same is to be implemented by 31/8/2025. This will be an essential part of information gathering to support the Annual Review for each resident. This review will be in in written, easy read and pictorial format and will capture the voice of each resident and the progression of their goals. All care plans will be updated to include information following appointments or interventions with health care professionals. These will be completed going forward following each appointment/intervention. Information sessions will be held with staff in Hazelwood on individual assessments and Personal plans which will include goal setting, care planning and an overview of documentation within the service	

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/08/2025
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's	Substantially Compliant	Yellow	31/08/2025

	wishes, age and the nature of his or her disability.			