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:	An Lochán
Name of provider:	Health Service Executive
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	23 June 2025
Centre ID:	OSV-0005708
Fieldwork ID:	MON-0046842

About the designated centre

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

The designated centre provides a residential service to four adults who have an intellectual disability. Residents may also have mental health needs and associated behaviours of concern. The centre can also care for residents with medical health care needs and a combination of nurses, social care workers and care assistants support residents with their care needs. Two staff members attend the centre each day and there is also a staff member present during night-time hours.

The centre is a two storey house which is located in a suburban area of a large town and there is ample communal, kitchen and dining areas for residents. Public transport links were available to residents and transport was also made available by the provider.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 23 June 2025	09:30hrs to 16:00hrs	Catherine Glynn	Lead
Monday 23 June 2025	09:30hrs to 16:00hrs	Alanna Ní Mhíocháin	Support

What residents told us and what inspectors observed

Overall, this is a person centred service that focused on residents care, support needs and was person centred, however minor changes were required in regard to governance and management, positive behaviour support and safeguarding, which is detailed under each regulation.

This was an unannounced inspection conducted in order to monitor on-going compliance with the regulations, with a specific emphasis on the safeguarding of residents, however minor improvements were required to further promote and enhance the safeguarding systems in the centre.

During the inspection, the inspectors spoke with the staff on duty, the person participating in management, and the person in charge. A variety of documentation was reviewed, including relevant safeguarding documents and plans in place. Documentation reviewed on the day specific to the focused inspection, included safeguarding documents, communication assessments, and staff rosters. Residents were observed throughout the day engaging in their activities and going out with staff for planned activities.

Following the introductory meeting with the staff team, the inspectors completed a 'walk around' of the centre. The centre was spacious and well-maintained, and laid out in accordance with the support needs of residents. For example, there was suitable space in the centre to afford residents time alone for space and relaxation.

Three residents lived in the centre, and they were all met at various times on the day of the inspection. All of the residents met and communicated in their manner with the inspectors. One resident spoke about their wish to move from the centre and was also aware of the provider's plan for a move at the time of the inspection. It was evident that staff were very familiar with the residents, their current compatibility issues, and the provider had plans in place to improve the residents' lived experience.

One resident met the inspectors in the staff office and spoke about their preference to live in another centre. They were reassured by the person participating in management and the plans for this residents move was openly discussed. The resident was happy with the support they received and went off to attend to their activities in preparation for an outing as part of their plans for the day.

Two other residents were enjoying a relaxed morning and were receiving support as they required. Inspectors observed and heard staff talking to residents in a reassuring and respectful manner. It was clear from all observations during the course of the inspection that residents were comfortable with staff members, and that they were supported in accordance with their needs and preferences.

The inspectors reviewed in detail the information in relation to any concerns raised,

both in the recording of the concerns, and any investigation that had taken place. Where serious concerns were raised the provider had ensured that external investigations had been conducted, and also put in measures to ensure the safety of all residents pending the findings of investigations.

It was evident throughout the inspection that both staff and management were person centred in their approach to care and support, and that residents were supported to make decisions, and that the safeguarding of residents was balanced with their right to positive risk taking.

Overall, inspectors found that this was a good service which was supported by the quality of the leadership team and the skills,experience and consistency of the staff team. Minor improvements were identified which are outlined in governance and management, positive behaviour support and safeguarding.

The next two sections of this report will outline the findings of this inspection in relation to the governance and arrangements in place in the centre and how these impacted on the quality and safety of safeguarding of residents at this centre.

Capacity and capability

There was a clearly defined management structure, and monitoring processes in place , but improvement was required as inspectors found that the documentation was unclear and duplicated in areas, for example personal emergency evacuation plans (peeps) which could result in staff not providing appropriate support in an evacuation. The provider had also failed to recognise and respond to all possible safeguarding concerns as discussed under relevant regulations.

There was a consistent and competent staff team, and the numbers and skill mix of staff were appropriate to the needs of residents.

Staff had been in receipt of appropriate training, and could discuss the learning from their training. They were also knowledgeable about the care and support needs of each resident, and of all relevant risks identified. This included potential risks posed to fellow residents, linked to behaviours of concern, choice of activities, or vulnerabilities.

The inspectors noted that the governance and management in the designated centre were supporting residents to make decisions about their lives, whilst ensuring their safety was of paramount importance. Inspectors noted that the provider had recognised and responded to a repeated peer-on-peer issue in the centre and had a time-bound plan in place to promote residents' safety in the centre.

Regulation 15: Staffing

The provider had ensured that sufficient numbers of staff to meet the needs of residents both day and night were in place. A planned an actual staffing roster was maintained as required by the regulations. The inspectors reviewed rosters for the four weeks prior to the inspection and found that the planned numbers and skill mix was maintained and that there was a consistent staff team who were known to the residents.

Inspectors met with three staff members, the person participating in management and person in charge later on the day of the inspection. They were found to be knowledgeable about the support needs of residents, and could readily answer questions relating to the safeguarding of residents, which included the current issues with compatibility for residents and plans that the provider had in place to address these issues. Staff were also very knowledgeable about the ways to respond to behaviours of concern for each resident, so as to ensure the safety of all residents living in the centre.

During the course of the inspection the inspectors observed staff interacting with residents in a caring and professional manner, and in accordance with their assessed needs. It was evident that residents were comfortable with the staff supporting them, and that they were familiar with them.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors reviewed the training in place in the centre from January to May 2025 ensure that staff received appropriate training and experience to meet the assessed needs of the residents in line with the statement of purpose and the size and layout of the service.

Training records showed mandatory and bespoke training provided in the centre, which inspectors found was up to date. Examples of staff training included: safeguarding of vulnerable adults, Trust in care, children first, and positive Behaviour Support. This ensured that staff were knowledgeable

Staff discussed the learning from various aspects of this training with the inspectors, and documentation reviewed by inspectors was in accordance with best practice, local policy and national policy.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found the governance and management strategies and processes in place in relation to the safeguarding of residents, and the response to any concerns, complaints or allegations were managed effectively in the centre. However some improvements were required to ensure the systems were robust and monitored effectively.

From a review of documentation, the inspectors noted the following areas for improvement. This included:

- The duplication of residents personal emergency evacuation plans, which could pose a risk to the resident. Inspectors noted there were four copies for the month of May 2025 for one resident.
- A behaviour support plan had not been updated for two residents in the centre since 2024 regardless of incidents or evidence of changes in behaviour management plans.

Where recent concerns were raised, investigations had commenced immediately, and investigations were completed appropriately. This ensured the safety of all residents pending the outcome of investigations. Responses to those raising possible concerns were made in accordance with the organisation's policy, and where appropriate external investigators had been engaged. All the appropriate authorities were informed and the necessary notifications had been made to the Chief Inspector within appropriate time frames.

Where investigations had been completed, where findings of abuse of residents had occurred, the inspectors were satisfied that detailed examination of all relevant information was complete. This resulted in the provider developing a plan to address the findings in a timely manner. For example, one resident was moving on from the centre due to recognised compatibility issues. The provider had a timebound plan in place for the resident to transition to another service in the region.

Staff were in receipt of support in the centre, and effective communication with the staff team was in place. This included regular staff meetings, a communication book, and staff also had access to the management team on a formal and informal basis. Safeguarding was a topic on each monthly staff meeting. This included a review of incidents, and a discussion on learning was completed. At all times discussion focused on the residents safety in all areas of daily life, but also the measures in place to support all residents in the centre. Restrictive practices were regularly reviewed and a record maintained of these reviews, this also reflected increases or decreases in practices if in place. This centre had very minor practices in place at the time of the inspection. Safety in relation to the management of any healthcare issues was discussed in relation to behaviours of concern.

Overall it was apparent that any concerns were taken seriously and appropriate actions and investigations were undertaken, and that safeguarding was given high

priority by the provider, the management team and the staff.

Judgment: Substantially compliant

Quality and safety

The provider had promoted residents access to person-centred care and support but some improvements were required to further enhance the systems in place. This included improvements in safeguarding and positive behaviour support, which is discussed in detail under each regulation.

There was a skilled and experienced staff team that was familiar with each resident's communication style and assessed needs. The voice of the residents was central to service provision, and a range of easy-to-read documents supported this to promote and support their understanding.

Each resident had a range of assessment tools, protocols and plans to guide staff in order to provide quality care and support. Where issues arose, these were dealt with promptly, and residents were supported to understand how to be safe. For example, incidents of peer-to-peer led the provider to assess residents' compatibility in the centre and subsequently led to a planned reconfiguration of the centre at the time of the inspection. This is discussed further in regulation eight.

Regulation 10: Communication

The provider ensured that residents were supported to communicate their needs and wishes.

Staff were observed speaking comfortably with residents. Staff were aware of the residents' particular communication needs and preferred topics of discussion.

Inspectors reviewed the communication profile that had been developed for one resident. This gave information to staff on how to present information to the resident so that they fully understood it. It also informed staff of the particular strategies used by the resident to express their needs, wishes and preferences. Inspectors noted that the provider had developed picture-based communication supports for residents to support their understanding of complex issues.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured that the needs of residents had been assessed and that the supports required to meet those needs had been put in place.

The inspector reviewed the assessments and personal plans of two of the three residents. These showed that the health, social and personal needs of residents had been assessed within the previous 12 months. These assessments were comprehensive and outlined the level of support required by residents to meet those needs. An annual review of the residents' personal plans had been completed. These had been completed in May 2024 and the person in charge reported that next the annual review of the personal plans were due to take place in the coming weeks. The annual review meeting was attended by the resident and a family representative, if appropriate. The meetings included a review of the residents' progress towards their personal goals and outlined the personal goals they had identified for the year ahead. There was evidence that residents had been supported to achieve their goals. For example, residents had recently returned from holidays and these holidays had been identified as goals at the previous year's annual review meeting.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had systems in place to support residents to manage their behaviour. However, improvement was required in relation to the documentation regarding the administration of medicine to support a resident's behaviour.

Inspectors reviewed the behaviour support plans in place for two residents. These had been developed by an appropriate professional. They gave information to staff on the environment and actions that should be taken to support residents with their behaviour. There plans also outlined reactive strategies that staff should take if the residents' became upset, anxious or if their behaviour became challenging. Staff demonstrated good knowledge of these documents and gave concrete examples of how they support residents.

Inspectors also reviewed the documentation in place in relation to the use of medication to support one of the three residents with their behaviour and found that it required improvement. There had been a number of changes to the resident's medication in recent months. Staff told inspectors about these changes and were clear on when the medication should be administered. However, the written guidance to staff was not clear. The medication administration protocol was reviewed by inspectors. They noted that the document contained handwritten updates that gave conflicting information to the resident's current prescription. Inspectors reviewed the daily notes for the resident when the medication was

administered. These notes did not always clearly document the reasons that the medication had been administered. In addition, the timings between medication doses was not in line with the timings specified on the medication administration protocol. Therefore, it was unclear if the criteria outlined in the medication protocol had been followed. This meant that the provider could not be assured that the medication was used only when necessary as the least restrictive option for the resident.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had put measures in place to protect residents from abuse. However, improvement was required in relation to the documentation of negative interactions between residents to ensure that all safeguarding incidents were recognised and addressed.

The provider had a safeguarding policy in place. Staff training records were viewed by inspectors and showed that all staff had up-to-date training in safeguarding vulnerable adults. This included all staff attending in-person training sessions. Inspectors reviewed the intimate care plan for one resident. This gave clear information to staff on how to support the resident.

There were no open safeguarding plans in the centre on the day of inspection. A safeguarding plan had recently been closed. This related to negative interactions between residents. The documentation relating to this safeguarding plan was reviewed by inspectors. It showed that the provider had followed all protocols and had continuously updated the plan in response to recommendations from the safeguarding team and the multidisciplinary team. Information relating to the safeguarding plan was shared with staff at team meetings. This showed that the provider was responsive to safeguarding incidents and implemented actions to keep residents safe from abuse.

The provider had developed risks assessments relating to negative interactions between residents. The risk assessments for two residents were reviewed by inspectors and they noted that these assessments were not always full implemented. Inspectors reviewed the daily notes for one resident from 1 May 2025 to the day of inspection that coincided with the administration of medication to support their behaviour. Inspectors noted three negative interactions between residents were recorded in this time period. There was no corresponding incident report for these interactions, as outlined under the residents' risk assessments. This meant that potential safeguarding incidents were not always reported, therefore the provider could not be assured that all incidents were assessed and addressed appropriately.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The rights of residents were promoted in this centre.

Inspectors reviewed the minutes of the three most recent residents' meetings. These showed that residents were supported to make choices and to have a say in the running of the centre.

Inspectors looked at two residents' annual reviews of their personal plans. These showed that the resident was consulted in relation to the development of their personal goals for the coming year, for example holidays and attending music events locally. They also showed that the provider accessed the services of independent advocates and other external support agencies to ensure that the rights of residents were upheld.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for An Lochán OSV-0005708

Inspection ID: MON-0046842

Date of inspection: 23/06/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1) An audit of document will be completed to identify issues with documentation such as the duplication of PEEPs noted in the report. 2) Training will be completed with staff team in An Lochan around documentation and this will include, duplication, archiving items, steps to follow so that all necessary documentation is completed, for example where a negative interaction is observed, daily notes are recorded detailing exactly what happened, an incident report is also completed, there is reference made in the handover report book, PRN protocols are not updated with handwriting but rather reviewed by the community nursing team or CNS in behaviors of concern, ensuring that they are clear, up to date and easy for staff to follow. The recording of PRN administration will also be included in this training so that all PRN use is noted in daily notes of resident with clear and detailed accounts of why it was administered. 3) Team leader will do adhoc reviews of daily notes to identify any issues with recordings that should also have been NIMS. 4) Issues with documentation will be discussed with staff team at next team meeting.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1) Training for staff on completing documentation will be delivered. This will ensure incident reports are completed where required. Incident reports are triaged twice weekly	

in the organization and the CNS behaviors of concern attends these meetings and this triggers reviews and updates to BSPs. 2) PRN protocols in relation to psychotropic medications will be completed and updated as needed by community nursing team members or CNS. These will reflect the prescription and tie in with BSPs where in place.

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: 1) Risk assessments in relation to residents will be discussed with the staff team, and their obligation to record all negative interactions in detail in resident's notes and complete incident reports and report to same to PIC/governance. 2) This will also be discussed with staff at team meeting and be included in staff training around documentation. 3) This will alert management to safeguarding concerns, behavioral concerns and/or compatibility issues escalating.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/08/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/08/2025
Regulation 08(5)	The registered provider shall ensure that where	Substantially Compliant	Yellow	30/08/2025

	there has been an incident, allegation or suspicion of abuse or neglect in relation to a child the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with.			