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:	Greenacres Lodge
Name of provider:	The Rehab Group
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	27 February 2025
Centre ID:	OSV-0005741
Fieldwork ID:	MON-0045913

About the designated centre

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

Greenacres Lodge is a residential service run by RehabCare. This centre provides a residential service for three residents aged over 18 years with a diagnosis of an intellectual disability and who require high levels of support. This service comprises of one house in a rural location on the outskirts of a village in Co. Clare. Transport is provided to access local amenities such as shops, restaurants and the provider's day service. Each resident has their own bedroom and share the main bathroom, the kitchen-dining area and communal areas. The model of care is social and staff are on duty at all times to support the residents. Management and oversight of the service is delegated to the person in charge with support from a team leader.

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
Thursday 27 February 2025	10:00hrs to 17:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was completed to assess the providers' compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities 2013 and, the National Standards for Adult Safeguarding (2019).

This inspection did find that improvement was needed in some areas to ensure full compliance. For example, in relation to the premises and staff training. Overall however, the inspector found that safeguarding residents from harm and abuse was embedded into the operation, governance and management of the designated centre. For example, since the last inspection of this centre the provider itself had reduced the number of residents that could live in the centre from 4 to 3. It was acknowledged in records seen and confirmed by staff spoken with that this reduced capacity had improved the quality and safety of the service.

The designated centre is located in a rural residential area. Transport is available. The house is a detached bungalow on a spacious site. Each of the three residents are provided with their own bedroom and they share the main bathroom. The house offers a choice of three communal and recreational areas and a spacious kitchen-dining area. A fourth bedroom has been converted to a staff office and sleepover room and at the time of this inspection the previous office was being used as a utility-laundry room. A pod to provide a sensory space had also been erected in the rear garden but was not yet in use. The provider had a programme of property maintenance but there were premises issues to be addressed such as completing works to permanently secure the rear garden.

The inspector was greeted by the team leader and the person in charge was also on-site. One resident had left the designated centre to attend their day service and two residents were in the centre being supported by staff who had arrived from the provider's day service. Ordinarily these two residents would also have left to attend the day service but they had specific transport requirements. The transport normally available to them was unexpectedly not available so the residents were in the centre while the person in charge sought to secure suitable safe alternative transport for them. As they day progressed transport that was suited and safe for the residents to use was sourced and one resident left with staff to enjoy a community based activity.

The residents living in this designated centre have high support needs in the context of their disability. These needs include communication differences both in their expressive ability and their ability to process and understand some verbal communication. Both residents made good eye contact when spoken with but generally were neither interested or perturbed by the presence of the inspector in their home. Residents did communicate their lack of familiarity with the inspector as they sought out familiar staff members to attend to their needs such as any requests for refreshments. As the day progressed one resident did smile at the

inspector, took the inspector gently by the arm and guided the inspector to a particular press in the kitchen or handed items to the inspector while smiling.

The staff team presented as familiar with the gestures and cues of the residents and the inspector found that arrangements such as continuity of staffing supported this. The inspector met with one staff member who had supported the residents in this centre and in another centre for over six years. The staff member could clearly describe the sense of safety and security that residents had when they had a staff team that was familiar to them.

A staff team meeting had been scheduled for the day of inspection. The person in charge was in the process of advising staff that they had deferred the meeting due to the fact that the residents' routines were different and the house was busy. One staff member who was not on duty arrived to attend the meeting and was very pleasant and unperturbed by the fact that it had been rescheduled. The person in charge had brought some scones and other snacks for staff creating a sense that while the meetings were detailed and resident focused the person in charge sought to make the meetings a pleasant experience for the staff team.

While there were communication challenges efforts were made to establish what it was that residents liked to do and enjoy such as what meals they enjoyed, places they liked to visit and activities that they enjoyed. Records seen reflected activities that responded to sensory needs such as walks in the beach or in forests. In the house the inspector noted a range of table-top activities and sensory items. One resident happily kicked as they wished a soft ball around the house.

Information such as how to make a complaint, how to access advocacy, the confidential recipient and the provider's designated safeguarding person was prominently displayed in a visual format.

Staff in the centre had completed a range of relevant training including training in human rights. There was evidence that the staff and management teams were continually advocating for residents such as for access and control of their finances and opportunities for residents to enjoy trips away from the designated centre.

Residents had ongoing access to family. Two residents were reported to have thoroughly enjoyed their recent birthday celebrations with family. Residents' families were consulted with in relation to the general operation of the service and the support and care provided. For example, the inspector noted the consultation that had occurred at a recent personal planning meeting. Feedback was also actively sought from representatives as part of the annual service review. The feedback on file was positive. One representative had previously reported their dissatisfaction with the quality of the service when more residents had lived in the house. They also acknowledged that this had been addressed by the provider and they were satisfied that the reduced occupancy had a positive impact on the quality and safety of the service. This positive impact was also evident in records seen by the inspector that reported a much reduced incidence of behaviours that challenged including responsive behaviours.

Support was provided as needed by the positive behaviour support therapist and the

plans and arrangements in place were under consistent review. For example, management, staff and the positive behaviour support therapist were actively working together to try to establish a better night-time routine for one resident. Overall however, the inspector found that while efforts such as these were made there was good tolerance of the choices and decisions that residents made such as where they slept and where they ate their meals. While restrictions were in place there was a risk based rationale for their use and no evidence that they impacted on resident quality of life.

The person in charge and the team leader could both describe and demonstrate to the inspector how safeguarding was embedded in the systems, processes and arrangements in place such as their presence in the house, the monthly staff meetings, the schedule of staff supervisions and the formal systems of quality assurance. They were both largely aware of where improvement was needed such as the refresher training for staff that was due and slightly overdue.

As the inspector was concluding the inspection the evening staff members had arrived on duty and two vehicles were available to the residents and the staff team. The evening was a pleasant spring evening and the residents and staff left to enjoy a walk in different locations.

In summary, the inspector found evidence of effective leadership, governance and management that was underpinned by an objective to protect residents from harm. Efforts were made to continually improve the quality and safety of the care and support provided and to promote resident's rights, health, physical and social wellbeing.

The next two sections of this report will describe that leadership, governance and management and how it protected residents from harm and promoted their rights and quality of life.

Capacity and capability

The inspector found suitable systems of governance and management. Responsibilities and reporting relationships were clear and understood. Management and staff understood their accountability for the safety of the service provided to residents. While some improvements were needed the provider was collecting and using information about the service to reduce the risk of harm to residents and to promote the rights and wellbeing of each resident.

Day-to-day management and oversight of the service was delegated to the person in charge. The person in charge had management responsibility of another designated centre located on the same site. The inspector noted throughout the day how the person in charge was accessible to both centres and responded to any queries or matters that arose.

The person in charge was supported by a team leader in each centre. The team leader had delegated responsibilities such as the planning and maintenance of the staff duty rota. The team leader was new to this role and told the inspector they had received induction and supervision, had ongoing support and guidance from the person in charge and feedback on their performance in the role.

There was a planned and actual staff duty rota and based on what the inspector observed and read the provider planned and managed staffing to reduce the risk of harm to residents and to promote their rights. For example, there was a minimum of three staff members on duty each evening when residents returned from the day service. This ensured appropriate levels of supervision and supported different choices and routines for the residents.

Good oversight was maintained of staff attendance at training and the person in charge and the team leader were aware of the refresher training that was due and overdue. However, no dates were available as to when this training would be completed.

The inspector reviewed the policy folder and saw that the provider had policies on the recruitment and selection of staff including a policy on its vetting of staff. The inspector reviewed two staff files and the content of the files were in line with the requirements of the regulations and the providers vetting policy.

The head of regulation monitored and ensured the providers policies and procedures were all up to date. This included policies seen by the inspector including policies on safeguarding, admissions, the recruitment and vetting of staff, staff training and development and safeguarding resident's finances.

There was a schedule in place for the completion of formal staff supervisions in addition to the informal supervision provided by the person in charge and the team leader. The person in charge convened monthly staff meetings and staff spoken with said that they could raise any queries and questions that they had. The inspector reviewed the team minutes folder, saw that there was very good staff attendance at the meetings and, safeguarding residents from harm and abuse was a standing agenda item.

There was a written code of conduct that was provided to all staff as part of their induction. In the designated centre the inspector saw that staff had access to copies of relevant guidance including the National Standards for Adult Safeguarding, set and published by the Authority.

Formal systems of quality assurance included the audits completed on a weekly basis by the team leader and the monthly audits completed by the person in charge of the support and services provided to residents. The provider in turn maintained oversight of the effectiveness of these local systems of management. The inspector saw that a timely annual service review was completed in 2023 and 2024 and the provider-led quality and safety reviews to be completed at least on a six-monthly basis were also completed on schedule. The inspector reviewed the reports of three provider-led reviews and saw that safeguarding residents from harm and abuse and safeguarding residents rights were standard lines of enquiry for completing these

reviews.

Regulation 15: Staffing

There was a folder available for inspection of planned and actual staff duty rotas. The rotas were well maintained and they reflected the staffing levels and arrangements described to the inspector. For example, the night-time arrangement of a staff member on waking duty and a staff member on sleepover duty. Overall, the inspector found that the provider was effectively planning, organising and managing the workforce. For example, the provider ensured that the number of staff was appropriate to meet the safeguarding needs of residents such as the supervision needed to prevent and respond to peer-to-peer incidents that could occur.

The continuity of staffing that residents benefited from was also provided. The inspector reviewed the staff duty rotas completed since December 2024 and these demonstrated this continuity. Regular staff known to the residents were advised of any vacant shift arising and they could choose to work these shifts. Records seen confirmed that they did work these shifts.

The inspector reviewed a sample of two staff files and found they contained the information required under Schedule 2, including evidence of Garda vetting and references including references from previous employers.

Judgment: Compliant

Regulation 16: Training and staff development

There was a supervision schedule in place to ensure staff were in receipt of regular formal support and supervision. The team leader confirmed they received ongoing guidance from the person in charge on the completion of these supervisions and would also shortly be commencing management studies supported by the provider. The person in charge and the team leader described how the provision of safe quality supports was a core theme explored during supervision. The inspector was advised that these supervisions were completed each quarter, that there was no requirement for enhanced supervision and no concerns arising from the supervision meetings. A staff member spoken with confirmed that they felt supported in their role and could give feedback and raise any concerns if they had them.

A sample of the minutes of three staff meetings held in late 2024 and January 2025 was reviewed. The meetings were occurring monthly as reported, the agenda and the items discussed were found to be resident focused. Safeguarding and protection was a standing agenda item as were restrictive practices and learning from any incidents that had occurred. For example, the plan for safeguarding residents from

the risk of harm from a peer was discussed as were the recent updates made to the safeguarding information folder.

Staff had access to a programme of training and good oversight was maintained of staff training requirements. The inspector reviewed the staff training matrix and saw that a training record was in place for each staff member listed on the staff duty rota. All staff had completed baseline training in child and adult safeguarding, in responding to behaviour that challenged including de-escalation and intervention techniques, in a human rights-based approach to health and social care, the use of restrictive practices while upholding human rights and, providing intimate care to residents. Training also completed by staff included training in safeguarding resident's finances, respecting and promoting equality and diversity and, the Assisted Decision Making (Capacity) Act 2015.

However, the matrix indicated and the team leader confirmed that a number of refresher trainings were due and were just overdue but dates for the completion of this training were not yet available. The refresher training due or overdue included the safe management of medicines, de-escalation and intervention techniques, manual handling and, HIQA online safeguarding modules.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were appropriate systems of governance and management in place to underpin the safe delivery and consistent oversight of the service. Roles and responsibilities were clear including designated safeguarding roles and responsibilities. The service was led by a capable person in charge who was appropriately supported in their role by the provider. The person in charge confirmed they had access as needed to their line manager and practical management support from the team leader. Overall, the inspector found that the local management team were implementing the provider's systems effectively to ensure they had good oversight in the centre.

The centre presented as appropriately resourced. For example, the designated centre was appropriately staffed with an experienced staff team. The provider had systems of quality assurance that were consistently implemented and that focused on providing assurance that residents were protected from harm and abuse. Safeguarding and protection, positive behaviour support, the use of restrictive practices and incidents were reviewed as part of these internal reviews. The provider was continually striving to improve the quality and safety of the service based on the information that it collated. The provider itself had reduced the occupancy of the centre based on its own monitoring of incidents that had occurred and the compatibility of residents to live well together. The person in charge and the team leader were open to learning and ways to improve and strengthen the safeguarding dimension of governance and management. For example, systems for

evaluating staff learning where on-line training was completed and refreshers on the staff code of conduct.

Judgment: Compliant

Regulation 3: Statement of purpose

The inspector read the most recent statement of purpose submitted to the Chief Inspector of Social Services and also read the copy held in the designated centre. All of the required information was in the statement but it was not all an accurate description of the facilities and services provided in the designated centre. For example, following changes made to the purpose of some rooms no resident had an ensuite bedroom as stated in the record and the laundry had relocated to the former staff office. This latter change was not reflected in the statement of purpose or the floor plans. The current staffing arrangement at night of a staff member on waking duty and a staff member on sleepover duty was also not correctly referenced.

Judgment: Substantially compliant

Quality and safety

In the context of their assessed needs there were limitations and challenges to the degree to which the residents living in this centre could safely self-direct their support and care and protect themselves from harm and abuse. The provider had arrangements in place that responded to these challenges and risks. Management and staff respected the choices that residents did make, recognised the individuality of residents and promoted their rights. Some improvement was needed in the process of personal planning and in the maintenance of the property.

Records seen such as a recent personal planning meeting and the staff team meeting records confirmed that residents' needs and their supports were consistently reviewed. Residents had the opportunity to attend a day service, take part in activities they enjoyed and to spend time with their family. The personal plan reviewed by the inspector positively described the resident's needs, likes, dislikes and preferences and, support that was provided such as from the behaviour therapist. However, while signed as reviewed at least every six-months the personal plan did not clearly set out the process of review, change and update with some information noted to have been gathered in 2023.

The personal plan included an positive behaviour support plan updated in 2024. The plan clearly set out the behaviours that could present, what could trigger those behaviours and the role of behaviour as a form of communication. Restrictive

practices were documented and regularly reviewed to ensure that they were the least restrictive, used for the shortest duration and proportionate to the level of risk that presented.

The restrictive practices that were in use were in response to risk that could arise to resident safety such as the unfastening of seat-belts while in the service vehicle or a resident's inability to safety use the kettle. The person in charge maintained a risk register that included these risks and these restrictive controls. The register of risks also included safeguarding risks and their management such as the risk for a peer to peer incident to occur between two of the residents in particular. Management and a staff member spoken with described how the reduced occupancy of the house had greatly reduced the risk for such incidents to occur. Overall, the inspector found that there was a tolerance to allowing residents to make choices that created some risk such as the longstanding preference of two residents to not wear footwear.

The inspector found that the provider was advocating on residents' behalf in relation to their rights and more significant decisions while also supporting them to make decisions in their everyday life. For example, the person in charge discussed with the inspector the ongoing efforts and improvements made in relation to resident access and control of their own monies. This was also referenced in records seen by the inspector such as the record of a recent personal planning meeting.

The location, design and layout of the house was suited to the needs of the resident. The house was found to be safe, warm and visibly clean during this unannounced inspection. The suitability of the house was improved by the reduced occupancy. The provider had a programme of property maintenance. For example, the main bathroom was recently refurbished. Two residents' bedrooms were nicely decorated and presented and the person in charge confirmed there was a plan in place to complete similar works with the third resident. However, there were works that needed to be completed to ensure residents had access to a safe and secure outdoor space and, the location of the laundry required further consideration by the provider

Regulation 10: Communication

As discussed earlier in this report the assessed needs of residents included communication differences including resident ability to understand more complex language and requests. Records seen described and the inspector saw how residents communicated what it was they wanted or did not want by expression, gesture, vocalisations or using objects of reference. A range of tools such as social stories and visual schedules were used as staff sought to maximise resident participation in decisions about their support and care and their understanding for example, of respecting the choices and personal space of others.

Communication limitations were recognised and respected. Management advocated on behalf of residents and staff spoke of consistently planning community based activities and locations so as to avoid behaviour that may be used by residents to

communicate their unease or unhappiness with a particular location. Residents had access to a range of media. Two residents had a longstanding history of not engaging with tools such as communication applications and personal tablets.

Judgment: Compliant

Regulation 17: Premises

The inspector found that the provider had considered safeguarding and resident safety when making decisions about the design and layout of the premises. For example, staff and management acknowledged the positive impact of the reduced occupancy on resident safety and quality of life. Residents had a choice of communal spaces and while not yet in use a pod to be used as an external sensory space had been erected.

Some changes had been made to the purpose of some rooms. For example, the staff office had relocated to the vacated bedroom and the vacated office had become a laundry and utility space. The inspector was advised that this was a temporary change and the plan was for the designated centre to share the laundry facilities of the adjacent designated centre. Staff reported that the current temporary location of the laundry was working well in terms of space and accessibility. There were matters that needed to be considered by the provider in relation to the proposed sharing of the laundry facilities.

For example, it would mean that this designated centre would not have its own laundry facilities or facilities that were easily accessible to residents so that they could participate in some laundry tasks as provided for in the regulations. The inspector noted that the proposed laundry space would have to be accessed by staff and residents down external steps or down a ramp unprotected from adverse weather. It was noted in one residents personal plan that they had the ability to participate in some aspects of completing their personal laundry.

The proposed laundry space was compact and currently served the needs of one resident. The provider needed to consider, risk assess and assure itself that the proposed sharing of the laundry provided adequate space that supported infection prevention and control on a day-to-day basis but also in the event of an outbreak in either designated centre.

The inspector saw that external remedial and upgrading works were not complete. For example, temporary metal fencing was still in place as opposed to a permanent secure, safer and more pleasing permanent fence. This had been an action in the providers own 2024 internal reviews.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector reviewed the risk register and a resident's individual risk management plan and discussed with the person in charge how risk in the designated centre was identified, assessed and managed. Risk management arrangements included the identification and learning from incidents and safeguarding incidents. Measures and actions in place to control safeguarding risks were centre specific and included the staffing levels and arrangements in place. These arrangements ensured appropriate levels of support and supervision in the centre and in the community, different routines and choices for residents. The resident's individual risk management plan was comprehensive and had been reviewed in December 2024. The plan included the controls in place that supported the resident to take some positive risks. For example, there was a plan for supporting the resident to maintain healthy feet including regular chiropody review given the residents preference to not wear footwear. The staff team had signed as having read the risk management plan.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector read and saw that the provider’s admission policy required an assessment to be completed of the impact on the quality of the existing service and, the possible impact on residents such as the risk of harm from a peer, in relation to any proposed admission. The centre was at capacity and there were no plans to admit another resident.

There was evidence of a collaborative approach to assessment and personal planning with the residential and day services working together and consultation with residents' representatives. The personal plan reviewed by the inspector was resident focused, set out how the resident communicated what they wanted and did not want, their known likes and dislikes and the personal goals to be achieved whilst keeping the resident safe. The plan sought to support the resident’s ongoing welfare and development such as enjoying a holiday with support from staff, and increasing their community access, visibility and meaningful participation.

However, the inspector noted that some of the information in the plan about the residents assessed needs and personal goals was dated from 2022 and 2023. This information had not been updated and was not reflective of the assessed needs that had been discussed at the recent personal planning meeting and with the inspector. For example, in relation to the resident's general health and presentation and the current sleep hygiene programme.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Positive behavioural support was informed by the guidance provided by the positive behaviour support team. The person in charge said that the positive behaviour support therapist could be accessed as needed. A staff member spoken with said that they could ask questions and would be asked for their experience of different support strategies, what worked and what did not work. It was recognised in practice and in the positive behaviour support plan that behaviour was at times a form of communication or a response to communication. The plan for example, referenced how the need for frequent prompting and guidance from staff could act as a trigger for behaviour. It was also accepted that behaviours could impact on the safety of others including their peers and could become a safeguarding concern.

Systems were in place for monitoring and analysing behaviour data and for maintaining oversight of the need for and the use of restrictive practices. These restrictions were largely of a physical and environmental nature such as restricted access to the electric kettle, to cleaning products and devices to ensure residents were safe in the vehicle so that they had and enjoyed ongoing community access. There was evidence of the use of alternatives to reduce the impact of the restrictions. For example, the inspector noted how a resident presented their beaker when they wanted tea and staff had a supply of tea ready in a flask to give to the resident.

Judgment: Compliant

Regulation 8: Protection

The provider had safeguarding policy and procedures. The person in charge and the team leader were found to be knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse. For example, the reporting and investigation pathway should an allegation be made against the person in charge. Safeguarding, recognising, reporting and responding to safeguarding risks including the risk of abuse and harm from a peer was strongly referenced in the providers own systems of quality assurance. The provider monitored and ensured that the Chief Inspector of Social Services was notified of any alleged, suspected or reported abuse. Safeguarding residents from abuse was a standard agenda item at the monthly staff meetings. Matters such as how minor or unexplained injuries sustained by residents were to be logged and reported were discussed with the staff team. Plans were in place detailing how residents were to be supported with their personal and intimate care needs.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found the designated centre was operated and managed in a way that respected and promoted the individuality and rights of each resident. For example, residents were seen to have good freedom in their home and ready access to the person in charge and the staff team. Resident choice was respected while staff sought to support residents to make decisions that might be better for their overall health and wellbeing. For example, management, staff and the positive behaviour support team were collaboratively working to establish a good night-time routine for one resident. In the interim, if the resident wished to sleep on the couch this was facilitated while everyone sought to understand why the resident preferred to do this. Different arrangements were in place for each resident as a person-centred approach was used. For example in relation to family contact and visits. There was a strong theme of advocating for residents on matters of significance such as the management of their personal finances and supporting residents as they transitioned from the courts service to the assisted decision-making framework.

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	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Greenacres Lodge OSV-0005741

Inspection ID: MON-0045913

Date of inspection: 27/02/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Review of training records to be added be Team Leader Weekly Audit. This will highlight to the Team Leader when training is due to be booked weekly and when staff are due to refresh online training. • PIC will also review training records monthly as part of the Residential service monthly Audit. • Quarterly, a local training audit will be completed and a copy will be made available to the team to prompt them to complete online training and face to face training will also be scheduled where needed. • All training identified as overdue during this inspection will be completed by 30.04.2025.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • PIC to update the SOP to ensure it accurately describes the facilities and services provided in the designated centre. The PIC will email the updated version directly to the inspector once the updates have been made, this will be completed by the 21.03.2025.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Temporary laundry facilities in the service utility room will be made permanent and appropriate piping for same to be installed by contractor. • Outdoor works will be completed, permanent fencing will installed. • Additional storage will be provided in the main service, this will allow for items stored in the pod to be moved and the pod will be converted to a sensory pod as originally planned when it was installed. This will be completed by 30.06.2025.	
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: • All personal plans will be reviewed and updated by key workers with support from Team Leader and PIC, this will ensure that going forward plans will reflect the current assessed needs of each of the resident. This will be completed by 31.03.2025. • As part of the PIC monthly audit, the residents file audits will be rotated each month which allows for each residents file to be audited once a quarter. Actions for improvement will be forwarded to key workers and Team Leader to complete.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/04/2025
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	21/03/2025
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended	Substantially Compliant	Yellow	31/03/2025

	following a review carried out pursuant to paragraph (6).			