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:	Colga Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	15 January 2024
Centre ID:	OSV-0004999
Fieldwork ID:	MON-0034600

About the designated centre

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

Colga Services provides a combination of residential and day supports to adults with an intellectual disability from a specified geographical area. The service is registered to accommodate up to eight residents. It currently provides a service for seven individuals of mixed gender who are over 18 years of age and have a mild to severe intellectual disability and or autism or mental health difficulties. The services provides six full-time residential placements and one respite placement. The service provides home-based services for some residents. Colga Services is made up of two houses close to rural villages. One of the houses is a two-storey house including a self-contained apartment. It has a large garden with separate areas for the house and the apartment. The other house is a bungalow with a garden, and is located within walking distance of the village. All residents have their own bedrooms. Residents are supported by a staff team that includes a team leader, nurses and support workers. Staff are based in the centre when residents are present and staff sleep over in both houses at night to support residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 15 January 2024	10:00hrs to 17:30hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to assess the provider's overall compliance with the regulations and to follow-up on the findings of the previous inspection carried out in January 2022. The inspection was facilitated by the person in charge and team leader, the inspector also had the opportunity to meet with three other staff members and with three residents who lived in the centre.

The designated centre comprised of two houses located within a ten minute drive of one another. Both houses were located in rural residential areas and close to a village. The inspector first visited the larger of the two houses and visited the other house in the afternoon. They met with some residents and staff and reviewed information and documentation. At the time of inspection, there were five residents living in one house and two residents living in the other.

Some residents had lived together for several years, got on well with one another and were supported by a stable staff team who knew them well. Some residents attended individual day services during the weekdays and some were supported with an individualised day programme from their house.

One house was modern and two storey in design and accommodated five residents. Residents had their own bedrooms with en suite bathroom facilities and one resident was accommodated in a separate self contained apartment. The second house was single storey in design and currently accommodated two residents who had their own bedrooms with a shared bathroom facility. This house had been extensively refurbished since the previous inspection with new fitted kitchen, furniture, flooring, doors and repainted throughout. Both houses were comfortable, warm, suitably furnished and decorated in a homely manner. The houses were spacious and bright with a good variety of communal spaces available for residents use. Both houses were found to be well-maintained and visibly clean. Residents had easy access to well maintained garden areas. The houses were accessible with suitable ramps and handrails provided at the entrance areas.

Residents bedrooms were spacious, comfortably decorated, suitably furnished and personalised. All bedrooms had televisions, adequate storage for personal belongings and were personalised with items of significance to each resident including family photographs, favourite posters, religious ornaments and sporting achievements. Residents had been consulted with and involved in selecting their preferred wall colours and in choosing soft furnishings for their rooms.

On the morning of inspection, some residents had left to attend their respective day services, another resident had gone for a drive with the support of staff and another resident went about their own routine in their own apartment. This resident did not wish to meet with the inspector. The resident remained in their apartment but the inspector observed that they were able to contact staff as required by ringing a door bell which could easily be heard by staff throughout the main house. The inspector

noted that staff were quick to respond to the resident when they rang the bell. Staff informed the inspector that this resident had planned to go for a drive with the support of staff in the afternoon in line with their preferred wishes. The resident had access to their own transport vehicle to attend activities and outings. Staff spoken with and files reviewed showed that the resident went out on regular day trips, including shopping trips, visited places of specific interest and had recently commenced swimming. The resident also enjoyed arts and crafts and making special occasion cards some of which they had recently sold in a local craft shop.

The inspector briefly met with another resident when they returned from their morning drive and also met with two residents who lived in the other house. While they were unable to tell the inspector their views of the service they appeared in good form and comfortable in the company of staff and in their environment. Staff on duty were observed speaking kindly and respectfully with residents and responding promptly to any requests for information or support. Staff spoken with were very knowledgeable regarding residents preferences, interests and support needs. Staff spoken with confirmed that they had completed mandatory training and that training was scheduled on an ongoing basis. Staff were aware of the individual communication supports required by residents. Some staff had received specific training including the use of the Lámh key word signing system and other staff spoken with advised that were planning to attend this training in order to assist them in communicating more effectively with residents.

From conversations with staff, observations in the centre and information reviewed during the inspection, it appeared that residents had good quality active lives, had choices in their daily lives, were involved in activities that they enjoyed, both in the community and in the centre. Residents were supported to take part in a wide range of activities, including regular walks and drives, and some enjoyed using public transport to visit places of interest. Residents regularly enjoyed shopping trips, eating out, going to public houses and attending music concerts. Others enjoyed going swimming, gardening, having a massage, attending art classes, the cinema and religious services. Another resident had recently enjoyed an overnight stay in a hotel. The inspector saw photographs of residents clearly enjoying many of these activities and events. The centre had its own vehicles, which could be used by residents to attend outings and activities. Residents also enjoyed spending time relaxing in the house, watching television, listening to music, completing table top activities including jigsaws and puzzles and going about their own routines. Residents' independence was very much promoted. Some residents enjoyed helping out with household tasks, such as attending to laundry, helping with the preparation and cooking of meals, grocery shopping and tidying up after meal times.

Residents were actively supported and encouraged to maintain connections with their friends and families. Visiting to the centre was being facilitated in line with national guidance. There was plenty of space for residents to meet with visitors in private if they wished. Residents were supported to regularly receive visits from family members while some residents regularly met with family members and friends for walks or coffee. Residents were supported to sent greeting cards and gifts to family members on special occasions. Other residents were supported to visit

family graves which was of great importance to them.

In summary, the inspector observed that residents were treated with dignity and respect by staff. Residents' rights were promoted and a range of easy-to-read documents, posters and information was supplied to residents in a suitable format. Staff continued to ensure that residents' preferences were met through daily consultation, weekly house meetings, the personal planning process and ongoing communication with residents and their representatives. However, there were many inconsistencies in the documentation reviewed, for example, records of weekly house meetings were not consistently recorded, some personal plans reviewed did not set out residents individual goals, progress on goals or evidence as to whether goals had been achieved or not.

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

Capacity and capability

The governance and management arrangements in place required review to ensure effective oversight and operational management of the centre in line with that set out by the provider in the statement of purpose. The person in charge of this centre had other managerial duties in the organisation and the inspector was not assured that they had adequate resources to ensure effective oversight of this centre.They were supported in their role by an area manager and team leader in the centre. There was an on-call management rota in place for out of hours and at weekends. The on-call arrangements were clear and readily accessible to staff in the centre.

The findings from this inspection showed that the provider had implemented the specific areas requiring improvement as outlined in the compliance plan from the last inspection, however, further review and improvements were required to the governance and management arrangements, the providers own systems for reviewing the quality and safety of care in the centre and to assessments and personal planning documentation.

There were adequate numbers of staff on duty on the day of inspection. While there was currently one nursing vacancy, the person in charge advised that two social care workers had been recruited and were due to commence in their roles. There were no gaps noted in a review of the centres staffing rotas.The staffing roster reviewed indicated that a team of consistent staff was in place to ensure continuity of support and care for residents. There was a mix of staff from both social care and nursing backgrounds which enhanced the lived experience of the residents.

The management team had provided ongoing training for staff. Training records reviewed identified that all staff had completed mandatory training. Staff spoken with confirmed that they had completed mandatory training including fire safety,

safeguarding and behaviour management. Some staff were due refresher training in relation to managing behaviour that challenged. Additional training including, safe administration of medicines and various aspects of infection control had also been provided to staff. Some staff had completed training on a rights based approach and as an outcome had ensured that all restrictive practices in use were regularly reviewed and reduced where deemed appropriate and safe. For example, restrictions regarding communication with a residents family had been enhanced.

The provider had some systems in place to monitor and review the quality and safety of care in the centre including an annual review and six monthly unannounced audits. The annual review for 2022 had been completed and the annual review for 2023 was due for completion. The provider continued to complete six monthly audits of the service. Some areas for improvement identified in the action plan from the May 2023 audit had still not been addressed. For example, works identified as required, including tarmac to the driveway and the provision of a storage shed had still not been completed.

The person in charge continued to regularly review incidents and accidents. However, the inspector was not assured that learning as a result of some incidents such as medication errors was being shared in a timely manner so as to improve the overall quality and safety of care in the service. The person in charge undertook to ensure that such learning would be shared at monthly team meetings during 2024.

While the provider had systems in place for the recording of weekly safety checks in the centre, weekly fire alarm checks, monthly infection prevention and control checks, these checks were not being consistently recorded. For example, monthly infection, prevention and control audits had not been completed since August 2023 and weekly safety checks had not been recorded since April 2023. Other records in relation to minutes of weekly residents meetings and monthly staff meetings were also not consistently recorded or up-to-date.

The person in charge spoke of a new computerised system which was now being used to assist in the monitoring and reviewing of quality and safety of care in the service. They advised that once all staff had received training on the use of the system that many of the weekly and monthly checks would be recorded on the system. They showed the inspector an example of a review which had been recently completed in relation to residents finances. No discrepancies had been noted in relation to individual residents finances.

Regulation 14: Persons in charge

There was a person in charge who was employed on a full-time basis and who had the necessary experience and qualifications to carry out the role. However, the person in charge had other managerial duties within the organisation including person in charge for another designated centre, as well as being the services coordinator for other services including day services. The person in charge did visit the centre and did attend monthly team meetings, however, they were not included

in the staff roster and did not have a routine and regular weekly presence in the centre, such as 20% of their time as outlined in the statement of purpose. These arrangements require review to provide assurances that they have the required resources to maintain effective governance, operational management and administration of the centre.

Judgment: Not compliant

Regulation 15: Staffing

The provider had ensured that the number and staff skill-mix at the centre was in line with the assessed needs of the residents. Staffing rosters reviewed showed that this was the regular staffing pattern. There was a team of consistent staff in place to ensure continuity of support and care for residents which included both nursing and social care workers. Staff spoken with were knowledgeable regarding residents' up-to-date support needs, and advised that staffing levels allowed them support residents, as required, and to participate in activities of their choice

Judgment: Compliant

Regulation 16: Training and staff development

All staff who worked in the centre had received mandatory training in areas such as fire safety, behaviour support, manual handling and safeguarding. Additional training in various aspects of infection prevention and control, administration of medication and first aid had aslo been provided to staff. Some staff had received specific training including the use of the Lámh key word signing system and rights based approach in health and social care services.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management arrangements in place required review to ensure effective oversight and operational management of the centre in line with that set out by the provider in the statement of purpose. The provider did not demonstrate that the person in charge had adequate resources to maintain effective oversight of the service.

Further oversight was required to ensure that providers own systems for reviewing

the quality and safety of care in the centre including, weekly safety checks, weekly fire alarm checks, monthly infection prevention and control checks, minutes of residents and staff meetings as well as residents' personal planning documentation were consistently recorded and maintained up-to-date. These issues identified on the day of inspection had not been recognised by the provider and indicated a lack of review and oversight. Actions relating to the external ground works identified as an outcome of a provider audit in May 2023 due to identified risk to residents had not yet been addressed. The driveway and external areas were still uneven with pot holes.

Systems in place for the review, investigation of and learning from serious incidents such as medication errors required review to ensure timely sharing of information and learning as a result of investigations.

Judgment: Not compliant

Quality and safety

The inspector found that the care and support residents received was of a good quality and ensured that they were safe and well supported. Residents that met the inspector appeared to be comfortable in their environment and with staff supporting them. In general, the provider had adequate resources in place to ensure that residents got out and engaged in their desired activities on a regular basis. This was largely due to appropriate staffing and transportation arrangements, as well as efficient planning and resident consultation, with regard to their preferred activity choices.

Staff spoken with were familiar with, and knowledgeable regarding residents' up to date health-care needs.They advised that residents were generally in good health. Staff reported that while some residents had specific health-care needs, their conditions were generally stable and well-managed. The inspector reviewed a sample of residents files and noted some inconsistencies. There was an assessment of need completed for each resident. Care and support plans were in place for all identified issues including specific healthcare needs, however, some support plans required review and updating to reflect residents up-to-date health status and support needs.

The inspector noted further inconsistencies in the personal outcomes documentation reviewed. Personal goals were clearly set out for some residents including evidence of review meetings and progress updates. Some resident's personal outcomes for the year were documented in an easy-to-read picture format. It was clear that these residents were supported to progress and achieve their chosen goals. Some files also contained many photographs demonstrating residents achievement of goals. However, there were no goals set out for another resident during 2023 in one of the files reviewed. The template being used to record the residents goals, hopes and

dreams, supports required to achieve the chosen goals and summary of priorities had not been completed.

Residents had access to general practitioners (GPs), out of hours GP service, consultants and a range of allied health services. Each resident had an up-to-date hospital passport which included important and useful information specific to each resident, in the event of they requiring hospital admission. Residents who required supports with communication had comprehensive plans in place, which were tailored to their individual communication preferences and support needs.

Safeguarding of residents continued to be promoted through staff training, regular review by management of incidents that occurred, and the development of comprehensive intimate and personal care plans. The support of a designated safeguarding officer was also available if required. There were no active safeguarding concerns at the time of inspection.

All staff had received training in supporting residents manage their behaviour. Residents who required support had access to psychology services and had positive behaviour support plans in place. There were some restrictions in use and all had been referred to the organisations human rights committee and had been recently reviewed and approved. Staff reported that they continued to promote a further reduction in restrictions in use and to trial alternatives that were less restrictive. There were written protocols in place to guide staff in the event that restrictions were required. However, the inspector noted that the documented protocol in place for a psychotropic medication used occasionally on a PRN 'as required' basis required review.

There were systems in place for the management and review risk in the centre. The inspector reviewed the risk register which had been recently reviewed and was reflective of risk in the centre.

Staff on duty demonstrated good fire safety awareness and knowledge on the workings of the fire alarm panel. Regular fire drills had been completed involving staff and all residents and records reviewed, provided assurances that residents could be evacuated in a safe and timely manner. All residents were ambulant and could mobilise independently. The fire equipment and fire alarm had been serviced. Fire exits were observed to be free of obstructions. All staff had completed fire safety training. However, further oversight was required to ensure that daily and weekly fire safety checks were completed and recorded. Records reviewed showed that weekly safety checks in the centre including weekly fire alarm checks were not consistently recorded.

There were systems in place to control the spread of infection in the centre. Issues identified during the last inspection regarding the storage of cleaning equipment and cleaning procedures had been addressed. There were colour-coded cleaning systems in place and cleaning equipment was suitably stored. The laundry areas were well equipped and maintained in a clean and organised condition. Staff had completed a range of training in relation to infection prevention and control. Both houses were found to be visibly clean.

There were systems in place for monitoring of medication management practices. All staff had received training in medicines management. Medicines were securely stored. A review of a sample of medicine prescribing and administration charts showed that medicines were being administered as prescribed. There were systems in place for checking medicines on receipt from the pharmacy, and systems in place for returning unused or out-of-date medicines to the pharmacy.There were regular reviews and audits being completed of medication practices in the centre.

Regulation 11: Visits

Residents were actively supported and encouraged to maintain connections with their friends and families. There were no restrictions on visiting the centre. There was plenty of space for residents to meet with visitors in private if they wished. Some residents received regular visits from family members and some residents were supported to regularly visit family members at home.

Judgment: Compliant

Regulation 12: Personal possessions

Resident's had adequate storage space to store personal belongings and clothing in their bedrooms. Resident's were supported to manage their laundry and have control over their own clothes.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to engage regularly in meaningful activities and the provider had ensured that sufficient staffing and transport arrangements were in place to facilitate this. The centre was close to a range of amenities and facilities in the local area and nearby city. Staff were cognisant in the scheduling of activities to ensure residents were provided with a choice of activities that they were interested in. There were several photographs showing residents clearly enjoying a wide range of activities during recent months.

Judgment: Compliant

Regulation 17: Premises

The centre was designed to meet the needs of the residents, was clean, suitably decorated and and maintained in a good state of repair internally, however, some improvements were required to the external driveway. Residents had access to large, well maintained outdoor garden areas. Substantial refurbishment works including the fitting of a new kitchen and appliances, new furniture, doors and flooring had been completed since the previous inspection. At the time of inspection, ground works included as an action from the provider led audit in May 2023 were still not addressed. The driveway and external areas were uneven with pot holes evident which had been identified as risk to residents.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the identification, assessment, management and on-going review of risk. The risk register had been recently reviewed and updated. There was an up-to-date health and safety statement available. All residents had a recently updated personal emergency evacuation plan in place. Medication errors had been recorded on the incident register which was reviewed regularly by the team leader and person in charge. There had been a number of recent errors recorded, however, these incidents had not been discussed with all staff to ensure learning and improvement to practice which posed a risk to residents.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for the management of fire safety. However, further oversight was required to ensure that daily and weekly fire safety checks were completed and consistently recorded. Some checks had not been recorded since April 2023. All staff had completed fire safety training and were knowledgeable regarding the workings of the fire alarm system and the evacuation needs of residents. Regular fire drills were completed involving all staff and residents. There was evidence that learning from recent fire drills had led to improvements in evacuation.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place for the safe prescribing, administration and storage of medicines in this centre. Clear prescription records were maintained. Records reviewed showed that medications were administered as prescribed. Medication audits were frequently carried out to identify any improvements that may be required and to ensure a high standard of compliance was maintained. All staff had completed training in medicines management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inconsistencies were noted in the personal planning documentation reviewed. Some support plans required review and updating to reflect residents up-to-date health status and support needs. For example, an epilepsy care management plan had not been updated since August 2022 and was not reflective of the residents current needs.

There were no goals set out for some residents during 2023. The template being used to record residents goals, hopes and dreams, supports required to achieve the chosen goals and summary of priorities were not completed.

Judgment: Not compliant

Regulation 6: Health care

Staff continued to ensure that residents had access to the health-care that they needed. Residents had regular and timely access to general practitioners (GPs) and health and social care professionals. A review of a sample of residents' files indicated that residents had been regularly reviewed by the psychologist, psychiatrist, physiotherapist, dietitian, dentist and chiropodist. Residents had also been supported to avail of vaccination programmes and national health screening programmes. Files reviewed showed that residents had an annual medical review.

Judgment: Compliant

Regulation 7: Positive behavioural support

All staff had received training in supporting residents manage their behaviour. Residents who required support had access to regular psychology review and had updated positive behaviour support plans in place. Staff spoken with were knowledgeable and familiar with identified triggers and supportive strategies. Restrictions in place were regularly reviewed. There was multidisciplinary input into the decisions taken, a risk assessment and clear rationale outlined for restrictions in use.

There were written protocols in place for all restrictions in use, however, the documented protocol in place for a psychotropic medication used occasionally on a PRN 'as required' basis required review. The documented protocol required updating to provide clear guidance for staff, including a clear rationale for its use and all other strategies to be trialled prior to administering the medication as a last resort. Staff spoken with clearly outlined the protocol used but this was not reflected in the written protocol. Staff spoken with confirmed that the medication had not been administered in recent months.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding of residents was promoted through staff training, management review of incidents that occurred and the development of comprehensive intimate and personal care plans. At the time of the inspection, there were no active safeguarding concerns at the centre. The inspector was assured that safeguarding incidents reported to the Chief Inspector in the past had been appropriately managed in line with the safeguarding policy.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to live person-centred lives where their rights and choices were respected and promoted. The privacy and dignity of residents was well respected by staff. Staff were observed to interact with residents in a caring and respectful manner. Information was available to residents in a suitable accessible format. Residents were supported to communicate in accordance with their needs and to avail of advocacy services. Restrictive practices in use were reviewed regularly by the organisations human rights committee.

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 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Colga Services OSV-0004999

Inspection ID: MON-0034600

Date of inspection: 15/01/2024

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: In order to increase the Person in Charges weekly time presence in the Designated Centre The provider intends to reduce their time demands managing others services by advertised an additional Team Manager role for other Service Areas where this Person in Charge currently oversees. Once this post is filled it will facilitate the Person In Charge of Colga Services with enhanced time for monitoring the operational management and administration of this Centre. Undertaking the above, will provide the assurances that the Person In Charge will have a routine and regular increased weekly presence in the Designated Center to enhance the governance and management oversight of the center.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC will have routine and regular weekly presence in the center as is outlined in the statement of purpose of this Designated Centre. To enhance the resources for this oversight an additional Team Manager post has been advertised recently for the whole Service area, this post, once filled will facilitate the Person in Charge with further time to audit and monitor and ensure effective and consistent governance, operational management and administration of this Designated center.	

In addition to address staffing vacancies and reduce locum cover, some Permanent Staffing posts have just now been filled. This staffing enhancement of these professionals will provide more regular fixed rosters which to will assist in the oversight and review of quality and safety of care within the Centre.
Through training and delegation of tasks to others we will ensure that weekly and monthly safety checks, such as fire alarm checks, infection prevention control checks, and minutes of residents and staff meetings as well are carried out as scheduled and updating and documented on the relevant portals within this Designated Centre.

The PIC will continue to review all Accident and Incidents reports and reviewing the data from incidents involving/ behaviors of concern / Medication errors that might have occurred between each team meeting. Through discussion at team meetings we will instill a culture of shared learning from these reviews. Where needed improvements or supports will be introduced or modified to safeguard all residents from any type of adverse event.

Funding will been sought for in 2024 for the ground works requiring tarmac to reduce the risk with the current surfaces. Pot holes will be regularly filled in the intern to help reduce risk on until the proper tarmac grounds works have been completed.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Funding has been sought for in 2024 for the ground works requiring tarmac to reduce the risk with the current surfaces. Pot holes will be regularly filled in the intern to help reduce risk on until the proper tarmac grounds works have been completed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Person In Charge will continue to review all AIRS reports quarterly in line with submission of HIQA quarterly notifications as is being completed at present. Also discussion will be held at team meetings going forward regarding the review of AIRS reports completed for this Designated Center. This will lead to further learning and drive improvements where required for the benefit of staff and Residents.

Where actions and learning are noted going forward these will be documented in team

meeting minutes for all staffs attention allowing all staff to implement in the improvements in practice.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A new portal electronic system is been used to retain records around compliance with Health and Safety. As we move from paper to this new system, staff training is being rolled out on how record these checks on this electronic system. During this transition phase to reduce risk of non-completion of fire checks the Team Leader has been delegated the responsibility to ensure that these checks are carried out on a weekly and monthly basis as per policy.	

Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The Epilepsy Care Plan was reviewed. Also Care Plans will be reviewed every year, however sections of the Personal Profile that need reviewing six monthly, annually and or as required will be completed by Keyworkers. Personal Outcomes for all residents will be reviewed quarterly by Keyworkers. For 2024 Resident's goals and Outcomes and achievements will be reflective of current needs and wishes. With the newly recruited Staff, Training in relation to Personal Outcome Measures will be provided. In addition our Quality Department have committed to providing refresher training and support to staff at a team meeting on how to complete the templates around personal priorities and other Personal Outcomes Documentation.	

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A PRN protocol that is in place will be updated or discontinued at a Mental Health Clinic scheduled for February 27th. The revised protocol PRN if still needed will provide clearer guidance for the staff, on its rationale for its use and all other strategies that need to be trialed as stated in the Residents Positive Behavior Support Plan prior to administering the medication as a last resort.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	16/04/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	01/07/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	16/04/2024

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
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.	Not Compliant	Orange	16/04/2024
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	15/04/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	01/03/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive	Substantially Compliant	Yellow	15/04/2024

	assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	15/04/2024
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	15/04/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive	Substantially Compliant	Yellow	27/02/2024

	procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			