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:	Hillside Apartments
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Short Notice Announced
Date of inspection:	20 July 2023
Centre ID:	OSV-0008464
Fieldwork ID:	MON-0040759

About the designated centre

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

Hillside apartments provides an individualised residential service for two residents who have separate living areas within the apartments. This centre can support residents with a primary diagnosis of intellectual disability. Both residents receive one-to-one support and staffing during the day and at night. Residents are supported by social care support staff at all times of the day and night, and oversight of the centre is provided by a person in charge and area manager. The centre is located within a short drive of a large town and transport is available for residents to access their local community. Each resident has their own bedroom and there is separate living areas for each resident which include sitting rooms, kitchen facilities and an office space with sleeping facilities for staff. The centre is decorated in-line with residents' needs and preferences and there is a small garden space for them to enjoy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 20 July 2023	11:00hrs to 16:30hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

This centre is run by Western Care Association in county Mayo. Due to concerns about the governance and oversight of Western Care Association centres and its impact on the wellbeing and safety of residents, the Chief Inspector of Social Sevices undertook a targeted safeguarding inspection programme which took place over two weeks in March 2023 and focused on regulation 7 (Positive behaviour support), regulation 8 (Protection), regulation 23 (Governance and management) and regulation 26 (Risk management procedures). The overview report of this review has been published on the Health Information and Quality Authority (HIQA) website. In response to the findings of this review, Western Care Association submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, but also to assess whether the actions of Western Care Association have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in county Mayo.

At the time of the inspection the provider had started on all proposed actions to strengthen the organisation's governance and management, however the inspector found that as this had just commenced, it had not had time to be fully embedded and established into the provider's structures and systems. In addition, a number of actions relating to positive behaviour support (regulation 7) and protection (regulation 8), risk management and safeguarding had commenced in line with the compliance plan response. The inspector found that the provider had made improvements in their governance arrangements at the centre and especially in the management of safeguarding concerns and positive behaviour support, these had occurred in line with the time frames of the provider's compliance plan and therefore required further time to be established and embedded into the service delivery. In addition, the provider required additional time to establish the improvements and show a sustained improvement in the governance and management of this centre and therefore in the long-term service delivery, safety and welfare of all residents.

This inspection was a short-notice announced inspection and was carried out to monitor regulatory compliance in the centre. As part of this inspection, the inspector observed the care and support interactions between residents and staff. The inspector met with one resident who lived in this centre, spoke with three staff on the day, and also viewed a range of documentation as part of this process.

The centre comprised of one single-storey detached bungalow, which had two self contained apartments for both residents. This centre provided full-time care to both residents with an individualised programme based on each residents' assessed needs. On the day of the inspection one resident was out attending planned summer activities for the day with staff support. At the time of the inspection two

residents lived in this centre.

The centre suited the needs of residents and provided them with a safe and comfortable living environment. This centre was located on the outskirts of a residential area in Castlebar, county Mayo. This gave residents good access to a wide range of facilities and amenities. Both individualised apartments were clean, bright, suitably furnished and decorated, and there was adequate communal and private space for residents. All residents had their own bedrooms and had the use of sitting room, kitchen and dining area, and an appropriate laundry area. The centre had garden areas to the front and rear of the centre, with further plans to develop the rear garden space to ensure that both residents had access to additional outdoor space.

As said earlier, the inspector met with one resident who returned from their outing to meet the inspector. The inspector saw how they spent their time, interacted with staff and management. The inspector noted the ease the resident interacted with everyone present and how all staff clearly understood the resident and their preferences during this time. It was clear during this time that the resident was very happy with the care and support they were receiving in this centre. Overall, the inspector found that both residents had moved from two previous services due to a change in mobility, and compatibility issues. The inspector found that the provider had ensured that a purpose-built facility was provided in response to both residents' changing needs.

Overall, it was evident from conversations with staff, and information viewed during the inspection, that residents had a good quality of life, had choices in their daily lives and views, and were supported by staff to be involved in activities that they enjoyed, both in the centre, at day services and in the local community. Throughout the inspection it was clear that the management team and staff prioritised the well being and quality of life of residents and there had been no negative impacts on this service or the residents who lived in this centre.

The inspector found that this inspection identified good practices throughout the regulations that were reviewed, there were come ongoing areas for improvement which had commenced in-line with the compliance plan response received, which will be discussed in the next section of this report.

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

Capacity and capability

The provider had good measures in place to ensure that this centre was well managed, and that residents' care and support was delivered to a high standard. These arrangements ensured that a good quality and safe service was provided to the residents who lived there.

The provider had submitted a compliance plan in response to findings from targeted inspections in January 2022. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in this centre. These included the introduction of regular meetings in the centre and also across the service in the county. The management staff spoke and discussed the enhanced arrangements as a result of the compliance plan response. They spoke about how this had commenced and how this was being implemented and they showed the inspector relevant documentation to support the improved systems spoken about that were introduced as part of this compliance plan response.

The inspector found that a clear organisational structure was in place to manage this centre. Furthermore, there was a suitably qualified and experienced person in charge established in this centre. The person in charge was based in an office in close proximity to the houses and they were responsible for two centres presently due to the recent reconfiguration of services in this area. This resulted in a reduction of the number of centres the person in charge was responsible for and showed the positive steps the provider was completing to enhance oversight at the centre. The inspector also noted that the person in charge had also coordinated staffing arrangements at the centre to ensure that residents being transitioned to the centre had consistent support, making them feel safe and supported throughout the process. Both residents and staff spoken with were familiar with the person in charge illustrating their presence at the centre. The inspector found that the person in charge had established effective support arrangements for the team and monitored this effectively. They also ensured that the staff team were aware of how to access support from the senior management team, when the person in charge was not available or present in this centre.

The inspector found that significant improvement to the overall organisational management processes had taken place following the initial site visit of this service in January 2022, prior to its registration. These improvements included the introduction of a range of governance and management oversight meetings. For example, the human rights committee had been re-established, were being held quarterly to review the use of restrictive practices, as well as weekly regulation, monitoring and governance meetings with other persons in charge. This forum was used as a tool for both the sharing and receiving of information from peers and senior management. The meetings also provided an opportunity for shared learning and experiences with fellow persons in charge. Furthermore, these meetings allowed the senior management team to provide workshops with external speakers on relevant areas of information to improve practices.

The inspector noted that there were strong systems in place for reviewing and monitoring the service to ensure a high standard of safety and care was provided and maintained. Unannounced audits were being carried out on behalf of the provider. These were being carried out twice each year and identified any areas

where improvement was required, with action plans to address. A detailed and comprehensive audit plan for 2023 had been developed which included a range of comprehensive audits to review the overall quality of care and safety in the centre. The person in charge and staff team were completing these audits in line with the organisation plan. These included monthly audits of incidents, medication management, residents' finances and personal planning. The sample of audits that the inspector reviewed showed a high level of compliance and actions arising had been completed as required. While this was a newly registered service, the provider had a plan to complete an annual review of the service's care and support provided to meet the requirements of the regulations.

A quality improvement tool and plan had been developed by the person in charge and management team, which was informed by the completed audits, six-monthly provider visits and other self-assessment processes as well as the planned annual review and inspections completed by HIQA for the centre.

The inspector also found that this centre was suitably resourced with appropriate staffing levels and skill-mixes to meet the assessed needs of both of the residents at all times especially in regards to accessing leisure opportunities and to facilitate day service attendance. A planned staffing roster had been developed by the person in charge, which were updated to reflect the actual daily staffing arrangements as required and were accurate on the day of the inspection.

The centre was suitably resourced to ensure effective delivery of care and support to residents. These resources included the provision of a safe, suitable and clean environment with adequate staffing levels to support residents with both their leisure and healthcare needs, as well as a dedicated vehicle for the centre. A range of healthcare professionals , including speech and language therapy, physiotherapy and behaviour support staff were also available to support residents where required.

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 12 actions aimed at improving governance arrangements at the centre, which would be completed by 31 January 2024. The inspector found that actions had commenced with all actions at the time of the inspection. For example, the provider had commenced reconfiguring its organisational regions, with recruitment of additional managers to ensure effective oversight arrangements were in place. This also included a plan for more regional as well as national organisational management meetings to commence.

Both the person in charge and person participating in management were aware of the provider's compliance plan response and spoke about the commencement of the

actions listed in the compliance plan response and their expected benefits. The inspector noted that while senior management structures were undergoing this review to address enhance oversight and governance, arrangements in place at the centre ensured the quality of care provided at the centre. At the time of the inspection, it was found that out of the 12 actions planned, three had been completed, with the remain nine in progress; but within agreed time lines of the provider's compliance plan response. Furthermore, were actions had been introduced, this had only been recently, and therefore further time would be required for these to become established and ensure the planned improvement in shared learning experiences, increased reporting structures across the organisation and enhance oversight.

Judgment: Substantially compliant

Quality and safety

The provider had good measures in place at the centre to ensure that the wellbeing and health of residents and keep them safe from risk and harm, evidencing that a good quality of care and support was being provided to residents.

The centre comprised of a single-storey detached dwelling on the outskirts of Castlebar, and was in close proximity to other residential and say services in the area. The house was close to a variety of local amenities such as shops, cafes, restaurants and other leisure facilities in this area. The house had dedicated transport, which could be used for outings, appointments or any other activities in the area. Some of the activities that residents enjoyed included outings to local places of interest, going for tea or coffee, listening to music or radio and watching television. The residents enjoyed walks and drives in the local areas and staff ensured that these activities were relevant to each residents abilities and preference.

The inspector completed a walk around of the centre and noted that it had been further personalised following the residents move into the centre in January 2023. The inspector found that this centre was comfortable, suitably furnished, decorated and furnished in a manner that suited the needs and preferences of the residents who live here. The inspector saw that there were family photos, artwork and various personal items displayed around the centre enhancing the homely feeling of this centre. The centre was clean and well kept but also provided both residents with ample private and communal space throughout the centre, and the provider had further plans to enhance the garden space to the benefit of both residents.

The provider had arrangements in place to safeguard the residents from any forms of harm. In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed

at improving the governance and management arrangements relating to protection at the centre. At the time of the inspection, the inspector found that all of these actions had been introduced. These related to an improved policy, development of a safeguarding oversight committee, ongoing safeguarding plan reviews, and face-to-face to staff training had commenced.

Both residents in the centre required behavioural support and had comprehensive behaviour support plans in place to guide all staff in how to support them. In response to the targeted safeguarding inspection programme, the provider had committed to completing seven actions aimed at improving governance arrangements in relation to positive behavioural support in the centre. At the time of the inspection, the inspector found that four actions had been completed, while three were in progress and still within the proposed time frames for completion. The inspector found that clear and comprehensive behaviour support plans were in place with access to the relevant multi-disciplinary support persons where required. Furthermore, the person in charge had worked proactively to reduce restrictive practices in use at the centre through more effective staff support and communication during residents' transition to the centre.

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to completing three actions aimed at improving risk management arrangements at the centre. At the time of this inspection all three actions were in progress as planned, and still within the specified proposed time frames for completion. These actions related to the development of quarterly incident report reviews, development of the incident management training module, and a review of the provider's risk management policy. The inspector found that previous risks relevant to the residents were no longer apparent following the reconfiguration of the service which had resulted in individualised services begin now put in place.

The person in charge and person participating in management, were very focused on delivering a person-centred, safe and quality service for the residents, by ensuring that their general welfare, social and leisure choices, and community activities were maintained and supported at all times. Both residents could take part in a range of social and developmental activities both at the centre and at their day services, as well as within the local community. Suitable support was provided at all times for both residents to achieve this in line with their preference, choices and interests as well as their assessed needs.

Regulation 13: General welfare and development

The provider had ensured that residents were supported and facilitated to engage in a range of activities relevant to their choices and specified preferences and in line with their assessed needs.

Judgment: Compliant

Regulation 17: Premises

The design and layout of this centre met the aims and objectives of the service and the needs of residents. The inspector found that the provider's reconfiguration plan had significantly improved the quality of residents' lived experiences at the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete three actions aimed at improving risk management arrangements at the centre. The provider proposed that these actions would be completed by 31 October 2023. At the time of the inspection, all three actions had not been completed, but were in progress in line with the provider's time frames for completion . These actions related to the development of quarterly incident date reports, the development of an incident management training module, and a review of the provider's risk management policy. The centre's management team were well aware of the proposed initiatives and felt that the changes were very beneficial to the residents, staff supporting them and overall service delivery.

Overall, the inspector found that the risk management was well managed in the centre, with some previous risks being removed due to the centre's reconfiguration into two individualised self-contained apartments.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions by June 2024, aimed at improving governance arrangements, as well as enhancing the therapeutic supports in relation to positive behaviour support in the organisation and the centre.

At the time of the inspection, the provider had appointed an interim head of clinical and community supports to promote effective oversight of multi-disciplinary supports required by residents and designated centres. However, although the inspector found that all of the proposed actions had commenced, this had been only recently, and therefore they had not yet been fully established and entrenched at the centre. Locally at the centre, the inspector found that residents had access to positive behaviour support and staff were knowledgeable about residents' needs in this area.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving governance arrangements in safeguarding at the centre. The proposed actions will be completed by 31 October 2023. At the time of the inspection four actions had been completed with one in progress.

Actions completed included the introduction of a face-to-face safeguarding training module for staff as well as an updated and enhanced safeguarding policy. The person in charge had ensured that staff were aware of the enhanced policy and had access to the new training module. In addition, they spoke about the importance of a clear and consistent process for the reviewing of and responding to safeguarding concerns and that they were involved in the provider's working group in this area of practice. The

The inspector found that presently there were no active safeguarding issues in the centre, and discussions on the improvements in safeguarding across the organisation gave further assurances to the centre's management team that any potential safeguarding concerns would be promptly addressed and suitably managed as required.

Judgment: Substantially 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 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Hillside Apartments OSV-0008464

Inspection ID: MON-0040759

Date of inspection: 20/07/2023

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:
This compliance plan is in direct correlation with the organisational plan and therefore the actions will run in line with this.

The provider will continue to implement and monitor progress of the compliance plan submitted to the authority in response to the findings of the overview report under four regulations. While some actions have been completed within the timelines provided in the plan, the remaining actions will be progressed for completion up to 31/01/2024.

An assessment of the frontline management structure has commenced to ensure equitable and effective operational management of each designated centre. This will be completed by 30/09/2023.

The implementation of the governance and quality improvement framework will commence by 30/09/2023, and will be subject to monthly monitoring or as required.

As part of this framework, a review of the current suite of audits will be undertaken to ensure,
- There is a standardised audit tool and smart action plan
- Support auditor to populate the audit tool with qualitative data
- Each audit has a specified timeframe for completion

Members of the Senior Management Team along with a Member of the Senior or Frontline Operational Management Team will undertake objective bi-annual unannounced visits to each designated centre from July to December 2023. On completion of these visits and reviews, a bi-annual thematic governance and quality improvement report was and will be presented to the Provider, Senior and Operational Management Teams in July 2023 and January 2024.

The provider is currently reviewing its staff training and development system and training needs analysis for staff in each designated centre and the organisation by 31/10/2023.

Monthly staff regulatory events are scheduled for the remainder of 2023.

The Quality, Safety and Service Improvement department is reviewing and updating a number of policies such as, staff support and supervision, listening and responding to people, restrictive practice, risk management and incident management policies.

The provider will continue to implement its Properties and Maintenance Plan, which will be monitored by the Properties and Facilities Manager, who will provide a quarterly progress report to the management team.

The organisation has scheduled a staff learning event for September and a second one will be scheduled for December 2023.

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

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
This compliance plan is in direct correlation with the organisational plan and therefore the actions will run in line with this.

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

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

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

Quarter 1 and quarter 2 incident data reports have been reviewed and analysed by the Incident Monitoring and Oversight Committee and communicated to the Person in Charge, Area Manager, Operational and Senior Management level and the Provider. This committee will continue preforming this function every quarter.

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

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

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

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

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

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

The standardised meeting agenda template has been implemented in this centre, which includes incident and risk management as permanent agenda items.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
This compliance plan is in direct correlation with the organisational plan and therefore the actions will run in line with this.

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

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

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

The provider will ensure,

• The Psychology team will develop a two-day core mandatory training module on neurodiversity, in consultation with the Staff Training and Development Manager, the Senior Operational Team and an external trainer. (31/10/2023)
• That all frontline staff will undertake the two days neurodiversity training as part of the staff induction programme.
• A planned schedule of this training will be delivered to existing staff between November 2023 and June 2024.
• On an on-going basis, all staff will receive refresher training in line with current practice as requirement arises.
• All staff will receive refresher neurodiversity training every three years.
• The neurodiversity training will be reviewed annually and updated in line with best practice by the psychology team and in consultation with the staff training and development department.

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

Key functions of the committee will include,

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

The psychology team will lead the review and update of the listening and responding to people policy (31/10/2023) which will include,

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

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

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

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

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: This compliance plan is in direct correlation with the organisational plan and therefore the actions will run in line with this. There are currently no safeguarding concerns in this centre. As per the provider's current safeguarding policy, all staff will be informed of their responsibility with regard to safeguarding reporting arrangements, thresholds for reporting and the steps to take when an issue of concern is observed or brought to their attention out of hours. The provider has a visual descriptor of all named designated officers and their contact details in visible locations throughout the Organisation's service location. The Provider will complete an internal investigation as may be required following the notification of a concern to determine if improvements may be required to organisation process and/or practice. The provider will ensure that arrangements for responding to safeguarding concerns are consistently implemented across all service locations in a timely manner to ensure safeguarding of all residents and that the regulator is notified as required under regulation 31. Where a safeguarding plan has been implemented, the Person in Charge and/or Area Manager will ensure all staff are fully aware of the contents of the plan and ensure that recommendations made are adhered to in a timely manner. In addition to the HSE online safeguarding training, the safeguarding training module has been reviewed and is actively being delivered through face to face learning events by trained designated officers employed by the provider. The Head of Clinical and Community Supports will continue to ensure that all safeguarding plans will be subject to six monthly reviews or sooner if required with the Person in Charge and/or Area Manager. The Interim Head of Clinical and Community Supports will establish a safeguarding oversight committee by the 31/10/2023 to ensure there is a robust system for reviewing all safeguarding concerns. This committee will, • Maintain a record of all open safeguarding plans in place. • Undertake audits on current safeguarding practices and oversight to ensure correlation with Organisational policy and best practice. • Critically examine safeguarding themes across the organisation • Review all internal investigations to determine where improvement may be required to the process to ensure effective safeguarding processes are in place to ensure the safety and wellbeing of residents. • Ensure that all staff are knowledgeable in relation to the contents, recommendations and implementation of all active safeguarding plans.	

• Review and update safeguarding policy as and when required.
• Complete a bi-annual report to the Senior Management team to form part of the bi annual thematic governance and quality improvement report which will be presented to the Provider, Senior and Operational Management Teams.

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

The Organisation's safeguarding policy and procedures have been will be reviewed and updated to reflect amendments to The National Safeguarding Vulnerable Persons at Risk of Abuse Policy and Procedures in July 2023.

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	31/01/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/10/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Substantially Compliant	Yellow	31/10/2023

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	31/10/2023