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:	Blackthorn Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Short Notice Announced
Date of inspection:	09 January 2024
Centre ID:	OSV-0008487
Fieldwork ID:	MON-0042047

About the designated centre

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

Blackthorn Resident Service provides full-time resident care to two adults with an intellectual disability. The centre comprises two neighbouring houses located in a residential area close to a busy town. Residents are supported by a team of social care workers. At night-time a sleepover staffing arrangement is in place.

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
Tuesday 9 January 2024	10:30hrs to 15:00hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This centre is run by Western Care Association in Co. Mayo. Due to concerns about the governance and oversight of Western Care Association centres and its impact on the well-being and safety of residents, the Chief Inspector of Social Services 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 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 Co. Mayo. At the time of this inspection a number of actions had been implemented, with more in progress for completion. The provider had made improvements in their governance arrangements. This included an assessment of the senior and frontline management structures and the reconfiguration of service areas with additional multi-disciplinary supports provided. These had occurred in line with timeframes of the provider's compliance plan and the management team met with said that there had been positive changes with regard to communication systems.

Blackthorn Residential Service was registered in July 2023 and this was its first inspection. It was carried out to monitor compliance with the regulations and was announced at short-notice. As part of this inspection the inspector met with the person in charge and the team leader. In addition, a review of the documentation and processes used in the centre was completed. There were two residents living at the centre, however, they were not present at the time of inspection.

On arrival, the inspector met with the team leader who facilitated the inspection. The person in charge arrived later. There were no residents present at the centre during the inspection.

The centre comprised two adjoining properties located in a residential area close to a busy town. One resident lived in each house. There was an access route between the two houses at the rear of the property. The houses were nicely decorated and were warm and welcoming. The living rooms were comfortable and the kitchens were well-equipped. The team leader told the inspector that one resident had a new suite of furniture which they picked for their sitting room. There was evidence of some wear and tear to the paint work and floor covering which the person in charge was aware of and was addressing if required.

The inspector found that the residents each had a comfortable home which met with

their needs and was a safe place to live. The properties were located within walking distance of the local town where access to shops and community facilities was provided. Through a review of the documentation and discussions with staff, the inspector could see that the residents were supported to choose activities that were meaningful to them and to have active lives in their community. The staff on duty told that the residents' independence and autonomy was supported through a positive risk taking approach. For example, arrangements were in place for residents to travel independently to their day service where appropriate to do so. One resident had a day service review recently and had additional day service options provided which they were reported to enjoy. In addition, both residents were supported to maintain contact with their families through visits to the centre, visits home and telephone calls.

Overall, it was evident from observations in the centre, discussions with staff and information reviewed that the residents had a good quality of life, where they made choices about what to do and were supported to be active participants in community life.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affects the quality and safety of the service provided.

Capacity and capability

The governance and management arrangements in this centre had changed recently, however, the inspector found that the persons employed had settled into their roles. The service provided was person-centred while ensuring that residents were protected from harm. In addition, the provider had taken action and upgraded the fire safety arrangements and the overall presentation of the premises as required. The inspector found that the areas for improvement related to the provider's compliance plan and the ongoing actions required therewith. These will be expanded on later in this report.

The provider had prepared a statement of purpose which was available to read in the centre. The inspector found that it was reviewed recently and updated to include the changes as outlined above. This was in line with the requirements of the regulation.

A review of Schedule 5 policies and procedures found that they prepared in writing, available for review and up to date. The provider had commenced an appraisal of some policies relating to safeguarding and protection, listening and responding to people and risk management. This is reflected under regulation 23 below.

The staffing arrangements in place were reviewed as part of the inspection. A planned and actual roster was available and it provided an accurate account of the staff present at the time of inspection. The provider ensured that the number and

skill mix of staff met with the assessed needs of residents and good consistency of care and support was provided.

A review of governance arrangements found that although there was a new management structure in place, it was defined in nature and staff were clear about their lines of authority. The role of the person in charge was supported by a team leader who was skilled and knowledgeable in the role. The six monthly unannounced provider-led audit was completed in November 2023 and a number of actions were identified and documented. The annual review of the quality and safety of the service was not yet due. An additional audit schedule was in place to assist with the day-to-day operational management of the centre. Staffing was provided by a core staff team with good consistency of care and support provided. Team meetings were taking place regularly. A review of incidents occurring in the centre found that they were clearly documented and if required, reported to the Chief Inspector in line with the requirements of regulation 31. However, the inspector found that although there was on on-call systems in place which was used to contact management, it required review to ensure that the same personnel were not 'on-call' all of the time and that the system was sustainable.

Overall, the inspector found that the staff recruited and trained to work in this centre, along with good governance arrangements ensured that a safe and effective service was provided. This led to good outcomes for residents' quality of life and for the care provided.

Regulation 15: Staffing

The provider ensured that the number and skill-mix of staff was appropriate for the needs of residents. Consistency of care and support was provided.

Judgment: Compliant

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. The provider aimed to have all actions completed by 31/01/2024. At the time of the inspection eight actions had been implemented with the remainder in progress.

Completed actions included an assessment of the senior and frontline management structures and the reconfiguration of service areas, the establishment of a new incident monitoring and oversight committee and a reinstated human rights committee, and the introduction of new arrangements for unannounced provider visits. In addition, a standardised monthly report writing template was introduced to

service and regulatory information events were provided for staff.

The inspector found four actions which had commenced and were progressing. The quality, safety, and service improvement department were finalising the review of service audits. The governance and quality improvement framework was in draft form and under review. A training and development project group was established and they had selected an information system which would enhance and support the staff training arrangements in place. Although the review of the policy, procedures and guidelines was completed by the provider, not all were finalised and circulated at the time of this inspection.

It was clear that the person in charge was well informed of the ongoing actions taken by the provider to strengthen the governance and management arrangements at both provider and service level. They spoke with the inspector about improvements in communication arrangements, opportunities for individual and shared learning, and consistency of the management systems in place. They said that although ongoing, the improvements had a positive impact on the quality and safety of the service provided at locally.

In this centre, the inspector found a defined management structure in place. The role of the person in charge was supported by a team leader who facilitated the inspection and were skilled and knowledgeable in their role. As this centre was registered recently, the annual review of the quality and safety of the service was not due. The six monthly unannounced provider-led audit was completed in November 2023 and a number of actions were identified and documented. An additional audit schedule was in place to assist with the day-to-day operational management of the centre. Staffing was provided by a core staff team with good consistency of care and support provided. However, the following required attention;

- The on-call system in place required review to ensure that it was in line with the provider's policy, met with the needs of the service and was sustainable in the long term.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which was subject to regular review and was in line with the requirements of Schedule 1 of the regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider and person in charge submitted relevant notifications as specified by the Chief Inspector within the timeframes required.

Judgment: Compliant

Regulation 4: Written policies and procedures

Written policies and procedures were prepared in writing and available in the centre. At service level an overall review of policies was in progress and this is reflected in regulation 23 of this report. At centre level the policies and procedures available were up to date and in line with the requirements of Schedule 5 of the regulation.

Judgment: Compliant

Quality and safety

The inspector found that the service provided in Blackthorn Residential Service was person-centred and residents were supported to live rewarding lives as active participants in their community.

The person in charge ensured that the resident's health, personal and social care needs were assessed. Care and support plans were developed, as required. Meetings occurred with the resident's family representatives where priorities and goals for the future were reviewed and agreed. The team leader told the inspector that residents enjoyed yoga, a social farming activity, going on day trips and evenings out. One resident was planning a birthday celebration.

Arrangements in place ensured that the resident was supported to achieve good health and wellbeing. Regular monitoring of the resident's health needs occurred. Where external health professional appointments were required, these were facilitated. For example, visits to the general practitioner (GP), dentist, audiologist and consultant-led cardiology care. In addition, residents had access to support from the multi-disciplinary team (MDT) if required. For example, social worker and positive behaviour support specialist.

As outlined, residents that required support with positive behaviour support had specialist supports in place. A further meeting was planned for the week after the inspection in order to finalise the behaviour support plan. The policy on behaviour support was up-to-date and staff training was provided. Restrictive practices were in use in this centre, however, they were reviewed regularly and some were removed recently as they were not longer required. Those used were the least restrictive and

only used when necessary.

There were no open safeguarding concerns at the time of inspection. A review of a safeguarding and protection plan found that it was completed in accordance with local and national policy. It addition, plans were linked to behaviour support strategies and corresponding risk assessments were in place. The safeguarding policy was up-to-date and all staff had completed training. Intimate care plans were available for review. The team leader was clear on what to do if a concern arose and the identity of the designated officer was clearly displayed in the centre. This was an action from the provider's compliance plan.

At this centre the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies. Policies on risk management were available for review and safety statements were up to date. Risk assessments for service level risks were in place and each resident had a personal risk management plan.

The provider had arrangements in place to reduce the risk of fire in the designated centre. These included arrangements to detect, contain, extinguish and evacuate the premises should a fire occur. The fire register was reviewed and the inspector found that fire drills were taking place on a regular basis. Residents had personal emergency evacuation plans and all staff had completed fire training.

As outlined, the premises provided was clean, comfortable and suitably decorated. The provider had taken action to ensure that matters identified previously were addressed. This included the provision of a safe rear access route between both houses and the removal of a water drainage system from the hot press in one property. At the time of inspection, both properties met with the assessed needs of the residents living there.

In summary, residents at this designated centre were provided with a good quality service where their independence and autonomy was promoted. There were good governance and management arrangements in the centre which led to improved outcomes for residents' quality of life and care provided. Ongoing progress with the actions committed to by the provider on their compliance plan would further enhance the service and the quality of the care and support provided.

Regulation 17: Premises

The premises provided was clean, comfortable and suitably decorated. The provider had taken action to ensure that matters identified previously were addressed. This included the provision of a safe rear access route between both houses and the removal of a water drainage system from the hot press in one property. At the time of inspection, both properties met with the assessed needs of the residents living there.

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 aimed to have all actions completed by 31/10/2023. At the time of the inspection two actions were completed and one was in progress.

Actions completed included the review of the risk management policy and the introduction of a quarterly process of incident review.

The inspector found that one action in relation to incident management training was in progress.

At this centre the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies. Policies on risk management were available for review and safety statements were up to date. Risk assessments for service level risks were in place and each resident had a personal risk management plan.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had fire safety management systems in place including arrangements to detect, contain and extinguish fires. Fire drills were taking place on a regular basis in line with the provider's policy.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents were found to have comprehensive assessments completed of their health, personal and social needs and were supported to achieve the best possible health and wellbeing outcomes. Annual reviews were taking place and residents' representatives were involved where appropriate.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve the good health and wellbeing outcomes. Where health care support was recommended and required, they were facilitated to attend appointments in line with their assessed needs.

Judgment: 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 aimed at improving behaviour support arrangements at the centre. The provider aimed to have all actions completed by 30/06/2024. At the time of the inspection the provider had completed six of these actions. The seventh action had commenced and was in progress.

Completed actions included the appointment of an interim head of clinical and community support and the appointment of additional multi-disciplinary supports. Under the leaderships of the psychology team, a governance and clinical oversight group and a behaviour support oversight group was established in order to co-ordinate the response to critical incidents. A review of the role and function of the psychology team was completed and guidance on the referral pathways was developed.

The inspector found that one action was in progress. The training module in neurodiversity was developed, a pilot was completed and that full roll out of the training module was planned.

In this centre, the inspector found that residents that required support with positive behaviour support had specialist supports in place. The policy on behaviour support was up-to-date and staff training was provided.

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 safeguarding arrangements at the centre. The provider aimed to have all actions

completed by 31/10/2023. At the time of the inspection, all actions were completed.

These included the establishment of a safeguarding oversight committee, updating of the providers safeguarding and protection policy and the introduction of a six monthly review system for open safeguarding plans. In addition, staff had access to face to face training in safeguarding and protection and new systems were in place to improve staff awareness of the contents and actions of open safeguarding plans.

At this centre, the inspector found that residents were supported to understand the need for self-care and protection. If safeguarding plans were used, the inspector found that the team leader had a good awareness of the plans requirements and that the actions were integrated into the behaviour support strategies and personal risk management plans.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Blackthorn Residential Service OSV-0008487

Inspection ID: MON-0042047

Date of inspection: 09/01/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has restructured the Senior Management team to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management and oversight. Under the remit of the HSE's Service Improvement Team the Models of Service sub-group has been merged as part of the Quality, Safety and Service Improvement workstream. The Provider has revised the unannounced visit template and unannounced visits are scheduled up to 31/7/2024. The next bi-annual thematic governance and quality improvement report will be presented to the Board in March. A learning management system has been agreed for staff training and development and the provider continues to facilitate monthly staff regulatory events. The quarterly properties and facilities plan is presented at senior management for oversight with regard to its monitoring and implementation. 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 through the submission of a report every 2 months. The provider submitted a business case to the commissioner of services in January 2024 for funding to strengthen the current on-call arrangement.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate	

action shared leaning takes place through the quarterly incident data reports. The incident management policy, risk management policy and associated training modules are in consultation stage with various stakeholders for organisational implementation. The pilot project will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Governance and Clinical oversight Group has been renamed as the Critical Response Team and meet on a quarterly basis. The Neurodiversity training module has been developed and will be delivered to staff by June 2024 with refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and the Listening and Responding Policy has been reviewed and will be considered by key stakeholders prior to implementation.	

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	31/07/2024
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	30/04/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Substantially Compliant	Yellow	30/06/2024

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			