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:	The Birches Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	09 July 2024
Centre ID:	OSV-0001500
Fieldwork ID:	MON-0044257

About the designated centre

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

The designated centre provides a residential service to eight residents who have an intellectual disability. All residents attend day services and the centre is staffed by both social care workers and care assistants. There is additional staff deployed in the evenings and at weekends to meet residents' needs and two staff support residents during night time hours on a sleep in arrangement. Each resident has their own bedroom and there is a sitting room and kitchen/dining room for residents' use. The centre is located in a housing estate and is within walking distance of the local town. Transport is provided on a shared basis and residents also have access to public buses and taxis.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 July 2024	12:00hrs to 14:00hrs	Ivan Cormican	Lead
Wednesday 17 July 2024	10:00hrs to 14:30hrs	Ivan Cormican	Lead
Tuesday 9 July 2024	12:00hrs to 14:00hrs	Anne Marie Byrne	Support
Wednesday 17 July 2024	10:00hrs to 14:30hrs	Anne Marie Byrne	Support

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to monitor the provider's compliance with the regulations and standards. The provider had applied to the Chief Inspector of Social Services to renew the registration of this centre.

Inspectors found that residents were supported to enjoy a good quality of life and they were active in their local communities. Some residents could access the community independently to meet up with family and friends while others were supported by staff. Information in relation to rights, complaints and safeguarding were clearly displayed in the centre and it was clear that the welfare and well-being of residents was actively promoted. Although the delivery of care in the centre had improved since the last inspection, inspectors found that additional improvements were required with regards to the oversight of care. This inspection highlighted issues in regards to staffing and the management of falls, and these issues will be discussed and the subsequent sections of this report.

This inspection was completed over two separate days and was conducted following the receipt of the provider's application to renew the registration of this centre. On the initial day of inspection, a resident became unwell and inspectors agreed with the provider to conduct the inspection over a second day. As part of this inspection, inspectors met with one resident on the initial day of inspection. On the second day of inspection, residents were leaving for their respective day services, and inspectors did not get the opportunity to meet directly with them. However, inspectors found that residents were active in regards to decisions about their care, and about the operation of the home, and it was clear that consultation with residents was part of day-to-day care.

The centre was a large detached property located in a residential area of a moderate sized town in County Galway. It was registered to cater for eight residents with disabilities. The centre was well-maintained both internally and externally, and had recently been renovated with a new kitchen installed, which give this area of the house a bright and modern feel. In addition, a decking area had been added to the rear garden and the person in charge reported that residents enjoyed this area in the fine weather. A resident had also planted a raised bed with lettuce and various salad leaves, and a staff member reported that they enjoyed attending to this area each day. Each resident had their own bedroom which they had individually decorated and there was an ample number of shared bathrooms and toilets. Residents displayed pictures of family friends and also attending social events which give the centre of homely feel. There was also a large reception room which was comfortably furnished.

A review of records indicated that residents were well supported to get out and about in the local community. Residents enjoyed going for coffee, attending local sporting events and also having meals out. Some residents could access the local

town independently, and a staff member reported that they would do their own shopping and meet up with friends and family in the local cafes. Residents were also actively consulted in regards to the running and operation of their home and their individual care. Residents met formally on a fortnightly basis to discuss topics and issues within their home such as complaints, rights, safety and respect. The staff who facilitated these meetings also discussed residents' satisfaction with local services such as their general practitioner, pharmacy and also banking services. In addition, residents attended an individual annual planning meeting, whereby, they discussed goals for the upcoming year and any amendments to the care plans, which they felt were required. An inspector noted at two residents' individual planning meetings, they both discussed their wish to retire from day services in the near future. A staff member spoke at length in regards to these plans, and senior managers from within the organisation had been made aware of these residents' wishes, and initial actions have been taken to support them in regards to their retirement.

Overall, inspectors found the day-to-day care for residents was pleasant and there had been notable improvements since the last inspection of the centre. However, there were issues in regards to staffing, and falls management for one resident. These issues will be discussed in the subsequent sections of this report.

Capacity and capability

Inspectors found that the quality of care was generally held to a good standard in the centre. Previous inspections of the centre had highlighted issues in regards to the oversight of care and meeting the assessed needs of residents. This was an unannounced inspection to assess the provider's compliance with the regulations. Previous inspections of the centre had raised concerns in regards to meeting the changing needs of residents, and also in regards to the oversight of care. However, this inspection highlighted a general improvement in regards to the provision of care; however, significant issues still remained in regards to staffing, risk management and the provider's governance and management arrangements.

The inspection was facilitated by the centre's person in charge, and also a newly appointed team leader. Both managers were found to have a good understanding of the residents' care needs, and also of the resources which were in place to meet those needs. They attended the centre throughout the working week, and completed a schedule of audits for the ongoing assessment of care and support offered to residents. In addition, a senior manager from within the service provider attended the centre on the final day of inspection and provided additional clarity in regards to some issues which were found on this inspection. They also had a good understanding of the residents' individual care need, and ongoing issues within the centre such as staffing and falls.

Although there have been marked improvements in the general provision of care,

this inspection raised concerns in regards to the response to falls for one resident. An inspector reviewed documentation which indicated that a resident had experienced falls during the day and also at night time. A review of care had occurred prior to the inspection, and recommendations were made in regards to the implementation of a falls monitor during night-time hours; however, this precaution was not in place on the day of inspection, to ensure the safety and welfare of that resident. This was brought to the attention of a senior manager prior to the conclusion of the inspection, and assurances were subsequently submitted in regards to the installation of a falls monitor for this resident.

The person in charge and the team leader highlighted that there have been significant issues prior to this inspection in regards to maintaining a consistent staff team. The person in charge highlighted that there had been increased dependency on agency staff and on some occasions agency staff would have been used who had not previously worked in the centre. On these occasions, the person in charge demonstrated that they were given a short induction and that they worked with the staff member who knew the residents' needs well. Although the rota was generally covered by both full-time, relief and agency staff, an inspector found occasions in which the centre was not fully staffed. A review of information also indicated that a resident had recently complained as they were not able to attend mass as they wished due to a shortage of staff. Further discussion with the person in charge indicated that the staffing issues were improving and the reliance on agency staff had reduced in the weeks prior to this inspection.

There had been recent changes in the governance and oversight arrangements within the provider which had a positive impact on the oversight of care in the centre. The person in charge and team leader reported regular contact with the provider's chief executive officer who held a weekly governance meeting with managers of all centres. The provider had completed an annual review of care following a consultation process with residents and their representatives as required by the regulations. The most recent provided unannounced audit had occurred in the weeks prior to this inspection and was found to be comprehensive in nature. This audit had identified several areas of care which required attention; however, this audit was not completed within the required timelines.

Regulation 14: Persons in charge

The person in charge was in a full-time role and they were suitably qualified and experienced. The attended the centre throughout the working week and they had set management hours to fulfil the duties of this role.

Due to the nature and size of this designated centre, the provider had also recently appointed a team leader to support the oversight of care. On the day of inspection, both managers had yet to decide which areas of care they would oversee and indicated that these arrangements will be set out post inspection. In addition, a senior manager provided further support to the centre and it was clear that all three

individuals had a good understanding of the residents' needs and the provision of care.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a staff rota which set out the day and night-time staffing arrangements in the centre. Three staff were assessed as required for both the morning and evening shifts, and two staff were in place for night-time hours on a sleep-in arrangement.

The person in charge reported recent issues in terms of ensuring that the centre was suitable staffed at all times. There have been a recent reliance on agency staff to fill gaps in the staff rota and an inspector noted occasions previous to this inspection, that the centre had operated below the recommended staffing requirement. The person in charge also highlighted recent developments in terms of recruitment and the reliance on agency staff had reduced in the weeks prior to this inspection. However, overall the provider failed to demonstrate that the centre was staffed according to its statement of purpose at all times.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had a mandatory and refresher training programme in place which assisted in ensuring that staff could meet the assessed needs of residents. Staff had completed training in areas such as behavioural support, fire safety and safeguarding.

The provider also facilitated team meetings and scheduled support and supervision sessions with the person in charge. The inspector found that these arrangements promoted an open and transparent culture and gave staff a platform to discuss care and any concerns which they may have.

Judgment: Compliant

Regulation 23: Governance and management

The provider had a management structure in place with clear lines of authority and accountability. The centre's person in charge attended the centre on a daily basis

and they were supported in their role by a team leader and also a senior manager.

Although there were governance and oversight arrangements in place, inspectors found that significant improvements were required in regards to the management of the centre. This inspection highlighted that the provider failed to ensure the recommended measures in response to recent falls had been implemented in a prompt manner. A senior manager submitted assurances post inspection in regards to the management falls, however, inspectors found the delay in the implementation of recommended measures had placed a resident at risk of further falls. In addition, a review of the rota indicated that the centre had, on occasion, operated below the required number of staffing and overall the provider did not demonstrate that the centre was suitably resourced in terms of staffing at all times.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge of the good understanding of notifications which are required to be submitted to the office of the Chief Inspector. A review of documentation in the centre indicated that all notifications have been submitted accordingly.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy, and an associated complaints procedure was clearly displayed in the designated centre. The provider had easy read information on complaints which facilitated residents to understand how to make a complaint, how it would be managed and resolved to their satisfaction.

Residents were actively informed in regards to complaints which was on the agenda of recent residents' meetings. There were no active complaints on the day of inspection and residents told inspector that they could go to the person in charge are any staff member if they wanted to discuss an issue or raise a complaint.

Judgment: Compliant

Quality and safety

The care and support required by the residents in this centre, was regularly re-

assessed for, and was well-known to the staff that supported them. Overall there were very good examples of care found upon this inspection, and residents regularly got out and about in their local community. However, this inspection did identify that there were some improvements required to aspects of risk management, medication management, and re-assessment and personal planning arrangements.

Due to the changing needs of some residents, there was a large focus placed in this centre on the regular re-assessment and review residents' personal plans. This was overseen by local management on an on-going basis, and there was good engagement with various multi-disciplinary professionals, as part of the re-assessment process. However, some assessments and personal plans were found to require further review, to ensure they gave better clarity on the specific care and support that some residents did require, particularly in relation to falls management and medication management.

In the months leading up to this inspection, the provider had placed significant emphasis on reviewing medication administration practices, due to a number of medication related errors which had been identified. This resulted in rectification of these issues, and fewer medication errors were now being reported, since this was responded to by the provider. Local management also maintained regular oversight of medication administration practices, which had been key in sustaining the improvements made. However, upon review of some prescription records, inspectors found some of these required review to give clarity on some prescribed dosages, and also with regards to ensuring the route of administration was documented for each prescribed medicine.

Risk was also another aspect of service that was subject to on-going review, in particular, where residents' changing needs identified new risks pertaining to assessed care and support needs. For example, in response to incidents which had occurred, specific falls management arrangements were required by one particular resident, so as to ensure their safety. Although the provider had sought the input of an allied health care professional in the re-assessment of this resident's aspect of care, they had not implemented one fundamental intervention that was recommended to them. Although written assurances were received, following this inspection, that this intervention was now in place, there was a lack of urgency on the part of the provider to implement this at the time it was recommended, or put interim safety arrangements in place until installation, prior to it being brought to the attention of local management upon this inspection.

Good oversight of fire safety practices were observed upon this inspection, with regular fire drills occurring to ensure residents could be supported by staff to evacuate the centre in a timely manner. Due to the use of agency staff by this service, local management were also cognisant in scheduling additional fire drills, to ensure the inclusion of these agency staff members in fire drills. Visual communication tools had also been developed to aid the evacuation of residents with specific communication needs, and inspectors were informed that these had been effective in supporting these residents to understand the centre's fire procedure.

Regulation 12: Personal possessions

Residents had their own bedrooms in which they kept the majority of the personal possessions. All residents had accounts with financial institutions and the staff member reported that some residents manage their own financial affairs. In addition some residents required support in regards to the payment for goods and services and also in relation to the oversight of their money. In order to safeguard residents' finances the provider ensured that there was oversight of spending for residents that required support. Staff maintained records of cash and cashless transactions and in general inspectors found that this area of care was held to a good standard. However, a review of records highlighted a cashless transaction whereby an associated receipt was not available for review. This had not been highlighted by the provider's oversight arrangements and required further review

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents were regularly out and about in their local communities which they could access independently or with the support of staff. Residents attended the respective day services throughout the working week, and some residents volunteered with the local tidy towns. The centre supported residents with an ageing profile and two residents had recently expressed wishes to retire. Inspectors found that the provider was at the initial stages of supporting these residents with their retirement.

Judgment: Compliant

Regulation 17: Premises

The premises was maintained to a good standard both internally and externally. A new kitchen had also been recently installed which give the centre a modern feel. Each resident had their own bedroom and residents could lock their bedroom door if they wished.

There was an ample number of shared bathrooms and toilets for residents to use. Overall, the centre had a warm and homely feel and it was clear that residents considered it their home.

Judgment: Compliant

Regulation 26: Risk management procedures

The identification of risk was largely attributed to the centre's incident reporting system, regular presence of management at the centre and also through daily staff handover. Where specific risks had been identified, there were good examples of where this was responded to by the provider, particularly in relation to medication management, whereby, the provider had effectively responded to a number of medication incidents, which had occurred in the months prior to this inspection.

However, in response to identified falls risk in this centre, there was a delay on the part of the provider to respond to these in the same timely manner. Over the course of this inspection, it was identified that the provider had not implemented a key risk management measure, which was recommended to them by an allied health care professional, two months prior to this inspection, following a re-assessment of a resident's falls risk. Although when brought to the attention of local management, they did implement this measure with immediate effect, there had been a lack of recognition by the provider to firstly oversee that this measure was implemented at the time it was recommended, or to secondly, put interim measures in place, until such a time as this key risk management measure was applied in practice.

Furthermore, although there was clear evidence that risk assessments were subject to regular review, some required further revision to ensure they better supported local management and staff, in their on-going re-assessment of risk in this centre. For example, risk assessments within the centre's risk register, relating to residents' changing needs, staffing levels, fire safety, medication management and falls management, all required review to ensure better accuracy in the overall risk rating, and better clarity on the specific mitigation measures that were specifically in place in this centre, relating to these key aspects of service.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had fire safety precautions in place, to include, fire detection and containment arrangements, there were multiple clear fire exits available, all staff had up-to-date training in fire safety, and regular fire safety checks of the centre were also carried out. Fire drills were occurring on a scheduled basis, and records of the last five completed drills reviewed by inspectors, gave assurances that staff could support these residents to evacuate the centre, in a timely manner. Each resident had a clear personal evacuation plan, and there was also a fire procedure displayed, to guide staff on what to do, should a fire occur.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

In the months prior to this inspection, this centre had experienced a number of medication related incidents, which had been effectively responded to, resulting in a decline in the number of medication errors being reported, at the time of this inspection. A number of staff were trained in the safe administration of medicines, and this aspect of service was regularly included as part of the provider's internal auditing process.

Two residents' medication prescription and administration records were reviewed by inspectors on the day of inspection. These were found to be well-maintained and legible; however, improvement was required to some aspects of these prescription records. For example, on one prescription record, it was observed that the same as-required medicine was prescribed twice for a resident. On another record, better clarity was required on the dosage to be administered for a recently prescribed medicine. A number of medicines were also observed to not have not have the route of administration documented on prescription records.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

This inspection found clear evidence that residents' needs were assessed for on regular basis, and personal plans were then developed to guide staff on how they were required to support each with resident with their individual needs. However, some improvement was found to be required to the information contained within some residents' assessments and personal plans, so as to ensure these gave better clarity on the care and support that residents received.

For example, due to the changing needs of one particular resident, they required specific care and support interventions in relation to their falls management. Although there was documentation in place for this aspect of their care, it didn't clearly outline the specific supervision and staff support arrangements, and various risk management measures that the provider had in place for this resident. In addition, at the time of this inspection, there were specific oversight of a resident's medication management, in response to recent changes to their assessed needs. However, at the time of inspection, a personal plan to guide on how the resident was being supported with this aspect if their care, was not yet put in place.

Assessments of need have been recently completed for all residents in the centre and they were found to be generally held to a good standard. They outlined the current staffing supports which were in place to meet the needs of residents and

also where additional care and support were required. Although the had been positive improvements in regards to these assessments, documentation reviewed for one resident did not clearly outline their capability and independence in terms of community access.

Judgment: Substantially compliant

Regulation 6: Health care

The provider had ensured that where residents had assessed health care needs, adequate arrangements were in place to support these residents. Residents' health care needs were subject to on-going review, and the centre was supported by a number of muti-disciplinary professionals in these reviews, as and when required. Where residents had medical appointments, staff were made available to attend these with residents. Any changes to the status of residents' health care needs, were communicated to all staff in a timely manner.

Judgment: Compliant

Regulation 8: Protection

There was no active of safeguarding plans required in the centre. Residents were supported to understand safeguarding procedures which were discussed at scheduled residents' meetings.

Information in regards to safeguarding was clearly displayed in the centre and all staff had received training in the application of safeguarding procedures. In addition, the person in charge had completed a recent audit of safeguarding which assisted in ensuring that this area of acre was held to a good standard at all times.

Judgment: Compliant

Regulation 9: Residents' rights

It was clear that residents' rights were actively promoted in the centre. Residents were actively consulted in regards to the running and operation of their home and also in relation to their individual care needs. They were well supported to access the local community and residents wishes in terms of retirement or been supported at the time of inspection. In addition, advocacy services were available if required and information on rights, safeguarding and complaints were actively displayed in

the centre.
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	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Birches Services OSV-0001500

Inspection ID: MON-0044257

Date of inspection: 09/07/2024

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The staffing rota is completed four weeks in advance by the Person in Charge. Where gaps in staffing are identified this is facilitated by the Ability West relief panel. All staff members are fully identified on the rota in full name and title. Since the date of the inspection, a further Social Care Worker and two Care Assistants have been hired. The Social Care Worker and one Care Assistant has commenced, and the second Care Assistant will commence the week of 12/08/2024. This will ensure compliance with the WTE stated in the Statement of Purpose.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: On the day of the inspection a sensor mat was installed on the resident's bed to alert staff of the resident's movement, should the resident leave the bed. This is to ensure staff have a prompt response in supporting the resident in her movements. This measure will be kept under review to ensure it is the most effective measure in supporting her needs. All falls continue to be reported on the QMIS system and monitored by the Person in Charge and Person Participating in Management. Any additional falls will be communicated with relevant multidisciplinary team members by the PIC and clinical input sought. The resident's risk assessment and falls care plan will be reviewed as falls occur by the Person in Charge and any additional change in needs or risk escalations will be communicated with management. The restrictive practice of the sensor mat is being referred to the Restrictive Practices Committee for approval. To ensure all staff are aware of any changes for residents or changes to their care plans, the staff communication book will be updated by the staff on duty, noting relevant changes and all staff will review, sign and date this before they commence their shift. Since the date of the inspection, a further Social Care Worker and two Care Assistants	

have been hired. The Social Care Worker and one Care Assistant has commenced, and the second Care Assistant will commence the week of 12/08/2024. This will ensure compliance with the WTE stated in the Statement of Purpose.

The Quality & Compliance Department will carry out an unannounced visit to the designated centre within the next six months and prepare a written report on the safety and quality of care and support provided in the centre. This will be completed by 31/12/2024.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Management of Service Users finances was discussed at a staff meeting on the 08/08/2024 and all staff were reminded that all transactions required a receipt as per the Ability West Administration of Service User Finances policy and procedure. The Administration of Service User Finances policy and procedure will be reviewed in-depth at the September staff meeting where all staff will sign off on same. The Person in Charge has completed a monthly finance audit for July 2024 and the Person Participating in Management will sample residents finances and receipts before 16/08/2024. Any actions identified will be addressed.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
On the day of the inspection a sensor mat was installed on the resident's bed to alert staff of the residents movement, should the resident leave the bed. This is to ensure staff have a prompt response in supporting the resident in her movements. This measure will be kept under review to ensure it is the most effective measure in supporting her needs. All falls continue to be reported on the QMIS system and monitored by the Person in Charge and Person Participating in Management. Any additional falls will be communicated with relevant multidisciplinary team members by the PIC and clinical input sought. The resident's risk assessment and falls care plan will be reviewed as falls occur by the Person in Charge and any additional change in needs or risk escalations will be communicated with management. The restrictive practice of the sensor mat is being referred to the Restrictive Practices Committee for approval.
To ensure all staff are aware of any changes for residents or changes to their care plans, the staff communication book will be updated by the staff on duty, noting relevant changes and all staff will review, sign and date this before they commence their shift.

The risk assessment in relation to falls and staffing levels has been reviewed and updated to ensure it accurately reflects the risk rating and includes all mitigating factors. An overall review of the centre risk register and associated risk assessments will be completed by the Person in Charge and overseen by the Person Participating in Management by 30/08/2024.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and

pharmaceutical services:
Documentation reviewed during inspection was amended with the relevant clinician week commencing 29/07/2024. A full review of all prescriptions, Cardex and MARS for all residents will be completed by 23/08/2024. The Person in Charge will ensure that all dosages and administrations routes are included on all relevant documentation following this review.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
On the day of the inspection a sensor mat was installed on the residents bed to alert staff of the residents movement, should the resident leave the bed. This is to ensure staff have a prompt response in supporting the resident in her movements. This measure will be kept under review to ensure it is the most effective measure in supporting her needs. All falls continue to be reported on the QMIS system and monitored by the Person in Charge and Person Participating in Management. Any additional falls will be communicated with relevant MDT members by the PIC and clinical input sought. The residents risk assessment and falls care plan will be reviewed as falls occur by the Person in Charge and any additional change in needs or risk escalations will be communicated with management. During outings, this resident is assisted with 1:1 staffing to assist in reducing the risk of falls.

A medication care plan for one resident was updated following the inspection and this guides staff in supporting the resident with their medication management, including times where she may refuse medication. This was completed 03/08/2024.

Relevant residents Assessment of Needs will be updated to outline their capability and independence in terms of community access. This will be completed by 13/08/2024.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	06/09/2024
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	13/08/2024
Regulation 23(1)(a)	The registered provider shall	Not Compliant	Orange	13/08/2024

	ensure that the designated centre is resourced to 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	18/07/2024
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/12/2024

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.	Not Compliant	Orange	30/08/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	23/08/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive 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	Substantially Compliant	Yellow	13/08/2024

	reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	13/08/2024