Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Seacrest Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	16 August 2023
Centre ID:	OSV-0001509
Fieldwork ID:	MON-0041186

About the designated centre

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

Seacrest Services supports up to seven male and female adults with a diagnosis of intellectual disability, who require a level of support ranging from minimum to high, and which may include co-morbidity. This service is a combination of residential and respite care. Respite care is provided on the basis of planned, recurrent, short stay placements. Seacrest is a two-storey house in an urban residential area. The house is centrally located and is close to amenities such as shops, restaurants, public transport, pharmacist and a church. All residents in the centre have their own bedrooms. The physical design of the building renders parts of it unsuitable for use by individuals with complex mobility needs or wheelchair users, although some residents with physical disabilities can be accommodated on the ground floor. Residents are supported by a staff team that includes the person in charge, social care workers and care assistants. Staff are based in the centre whenever residents are present, including at night time.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Wednesday 16 August 2023	09:30hrs to 17:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to follow up on non compliance's identified during the previous inspection of this centre, to assess the provider's compliance with specific regulations and also the regulatory compliance plan submitted to the Chief Inspector of Social Services on an organisational level.

The inspector met and spoke with staff members on duty, the team leader and the person in charge. The inspector also met and spoke with all four residents during the day.

The centre comprises a large detached house located in a quiet residential area of the city suburbs and close to a range of facilities, amenities and shops. On the day of inspection, there were four residents living in the centre and one resident was in hospital recovering from a recent surgery. Some residents had complex health care needs, including physical, medical, mental health and mobility issues. Three residents were wheelchair users, some residents were assessed as requiring two staff for transfers using a hoist and some residents required a high level of supervision to ensure their safety. Residents had a range of social care needs and all now attended a local day service during the weekdays. The day service was closed for holidays at the time of inspection.

On arrival in the centre, the inspector met with two residents, one resident was being supported with personal care while another had gone to the local hairdresser. One of the residents was happy to show the inspector around the house. The house was spacious, bright and comfortably furnished in a homely style. Each resident had their own bedroom. Bedrooms were spacious, had a wash hand basin, television and adequate storage space for personal items. All bedrooms were personalised with residents' own effects, family photographs and other items of significance to them. There was an adequate number of toilets and showers located on each floor. There was a variety of communal day spaces provided including a large sitting room, kitchen with dining area and activity room. There were framed photographs of residents enjoying a variety of activities displayed throughout the communal areas of the house. There was a laundry room which included storage for cleaning equipment, a staff office and staff sleepover bedroom provided. Residents had access to a large landscaped garden and patio area at the rear of the house. The ground floor of the house and the external garden areas were accessible for wheelchair users with suitable ramps and handrails provided. The house was generally found to be well maintained in a visibly clean condition. The external walls of the house had been recently repainted and the external grounds were well maintained. Other improvement works to the house had also been completed including the provision of a dedicated store for the storage of equipment and a large accessible shower room had been provided to the ground floor. Staff were in the process of renovating a vacant ground floor bedroom and had ordered a new specialised bed to better meet the needs of the resident who was due to be discharged from hospital. Further improvement works including the upgrading of the

office, replacement of some shower heads and further internal painting were scheduled. There were adequate aids and specialised equipment provided to meet the needs of residents.

The inspector met with all four residents later in the morning. They all appeared happy and comfortable as they chatted and interacted with staff in a relaxed and jovial manner. Some residents told the inspector how they liked living in the house as it was close to the bus stop and lots of amenities. One resident spoke about attending mass every Sunday in the local church which was just a short walk away. They were also looking forward to attending country music concerts at the weekend and again the following week. They mentioned how all the residents had enjoyed being out for lunch the previous day at a local golf club. Residents also recently enjoyed birthday celebrations and attended a garden party. One of residents showed the inspector photographs of residents enjoying these events on their hand held computer tablet. Residents were looking forward to going away in September for a planned holiday to an activity resort. One of the residents told the inspector how they liked to help out with cleaning duties and enjoyed sweeping the floors.

The inspector observed all residents sitting together in the kitchen having their lunch. Some residents required support with modified consistency diets as recommended by the speech and language therapist. Staff were knowledgeable regarding this guidance and were observed implementing it in practice. The weekly pictorial menu plan was displayed and residents told the inspector how they choose their preferred meals at the weekly house meetings. They mentioned how they sometimes dined out or could choose to get an take away meal. The inspector observed that residents were offered choice of drinks and snacks throughout the day.

During the afternoon, three of the residents attended a reflexology session in the house and another resident was supported to attend a specialist footwear appointment. Staff advised that residents enjoyed the regular reflexology sessions and also the twice weekly music, dance and arts class in house. Residents also attended regular physiotherapy and massage sessions as well as weekly music sessions while attending the day service.

Residents were supported and encouraged to maintain connections with their friends and families. There were no restrictions on visits to the centre. Residents spoke of regularly visiting their friends and family members.

Throughout the inspection, it was evident that staff prioritised the welfare of residents, and that they ensured residents were supported to live person-centred lives where their rights and choices were respected and promoted. Staffing levels in the centre were stable with three staff on duty each day. A pictorial staff roster was displayed in the hallway so that residents knew what staff to expect on duty. It was obvious from interactions observed that residents and staff knew one another well. Staff on duty were observed speaking kindly and respectfully with residents, listening attentively and responding promptly to any requests for information or support. Staff and residents chatted and sang together in a relaxed and familiar way. Staff spoken with were very knowledgeable regarding residents wishes,

preferences and interests.

While issues identified at the previous inspection had largely been addressed, the provider needed to ensure further oversight of the management of safeguarding incidents to ensure that they were promptly addressed, investigated and updates submitted to the Chief Inspector.

In summary, the inspector observed that residents were treated with dignity and respect by staff throughout the day. Residents were comfortable, relaxed and happy living in the centre. It was evident that residents had a good quality of life, had choices in their daily lives and that their individual rights and independence was very much promoted.

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

Capacity and capability

This designated centre is run by Ability West. Due to concerns in relation to Regulation 23: Governance and management, Regulation 15: Staffing, Regulation 14: Person in Charge, Regulation 5: Individualised assessment and personal plan, and Regulation 26: Risk management procedures, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider’s registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in April 2023 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan the provider has outlined an action plan to the Chief Inspector highlighting the steps they will take to improve compliance in the registered centres. These regulations were reviewed on this inspection and this report will outline the findings found on inspection.

Notifications concerning recent alleged safeguarding incidents along with information received by the office of the Chief Inspector were also used to inform this inspection.

The findings from this inspection showed that the provider had implemented some improvements to the overall governance and management arrangements in the centre. The provider had generally implemented the compliance plan submitted following the last inspection. Improvements were noted in relation to records that were required to be maintained, restrictive practices, on-call management arrangements, the premises, risk and wound management. However, systems in place for the management and oversight of safeguarding incidents required urgent review to ensure that they were promptly addressed, investigated and that any learning as a result was shared and used to inform improvements to the service. Improvements were also required to ensuring that the standardised assessment of

need process 'My support needs assessment' was completed in line with the regulatory plan submitted to the Chief Inspector.

There was a clear management structure in place. The person in charge worked full time, they were also in charge of two other designated centres. They normally worked two days a week in the centre and were supported by a team leader who had been appointed since the previous inspection. The team leader worked full time in the centre and had been allocated 18 hours a week to their operational management role. The person in charge and team leader were supported in their roles by a senior manager. In line with the regulatory plan submitted, the person in charge and team leader confirmed attendance at a number of recent training workshops which had been arranged by the provider to support and enable them in their roles. Training included roles and responsibilities, risk management, Flex maintenance system, quality enhancement plans and discussion on new templates, filing systems and assessments of need being implemented by the provider across all services.

There were now formal on-call arrangements in place for out of hours seven days a week. The details of the on-call arrangements were notified to staff on a weekly basis and clearly displayed in the centre. Staff spoken with were familiar with the arrangements in place.

On the day of inspection, there were sufficient staff on duty to support the residents assessed needs in line with the statement of purpose. There were three staff on duty during the morning and throughout the day and evening with one staff member on duty at night time. Staffing levels at night time had been reviewed since the last inspection. There was a second staff member at night time to meet the needs of a resident who required additional supports, however, this resident was in hospital at the time of inspection. There was one staff vacancy which was currently been filled by relief staff. The staff roster reviewed showed that this was the regular staff pattern. A new four week rolling staff roster had been drafted and was due to be implemented in September. Staff spoken with advised that the current staffing arrangements allowed them support residents make daily choices regarding their preferred activities and outings.

Staff training records reviewed indicated that that all staff had completed mandatory training. Additional training in various aspects of infection prevention and control, skin integrity, use of hoists, medication and epilepsy management and feeding, eating, drinking and swallowing guidelines had been completed by staff. The team leader and person in charge had completed training on risk management. Further training was scheduled for staff on restrictive practices and risk management on 21 August 2023. Training was also planned in assisted decision making and rights.

The provider had systems in place to monitor and review the quality and safety of care in the centre including an annual review and six monthly unannounced audits. Improvements identified as a result of these reviews had been included in the quality enhancement plan. The person in charge advised that the plan will be reviewed and updated on an ongoing basis to ensure that all identified areas for improvement are addressed promptly. The person in charge and team leader

continued to regularly review identified risks, accidents and incidents, restrictive practices, medicines management, infection, prevention and control, staff training, fire safety and residents finances. Monthly team meetings were taking place at which identified areas for improvement, risks and staff training updates were discussed and learning shared. There was also evidence of consultation with residents and regular house meetings where the views of residents were sought and information shared. Residents and their families had recently completed questionnaires indicating positive feedback and satisfaction with the service provided.

Systems in place for the management and oversight of safeguarding incidents required urgent review. A recent incident reported to the Chief Inspector had not been managed or investigated in line with the safeguarding policy in a timely manner. Preliminary screening did not take place within the time lines set out in the providers own safeguarding policy. The inspector was also informed of lengthy delays in requesting and obtaining statements from staff leading to undue delays into the investigation and resulting outcome.

At the time of the previous inspection the senior management team undertook to submit updates to the Chief Inspector regarding the progress and outcomes of a number of safeguarding investigations which were taking place at that time, however, these updates had not been provided.

Information of concern was received by the office of the Chief Inspector indicating that families had not been updated and provided with the outcome of full investigation reports following alleged safeguarding incidents which took place in 2019.

A safeguarding incident involving financial donations recently notified to the Chief Inspector was being investigated by the Gardai and the provider at the time of inspection. However, the inspector was not assured that the provider had adequate polices, procedures and guidance available to staff to ensure that residents finances were adequately safeguarded. While the person in charge had put in place improved protocols to protect and safeguard monies as a result of learning from the incident, the provider had not updated their polices or provided updated guidance for staff. The inspector reviewed a sample of residents accounts ledgers. Records were clearly maintained, balances were checked and signed by two staff on a daily basis. There were no discrepancies noted.

Regulation 14: Persons in charge

There was a person in charge who had responsibility for the day to day management of the centre. The person in charge worked full-time and had the required qualifications and experience to manage the centre as required by the regulations. They were knowledgeable regarding the regulations and their statutory responsibilities. They were well known to staff and residents in the centre.

Judgment: Compliant

Regulation 15: Staffing

There was an adequate number of staff on duty on the day of inspection to meet the needs of residents. A team leader had been appointed since the previous inspection. Staff had access to a nurse within the organisation to provide nursing support if required. There was a planned and actual staff rota showing staff on duty. Records reviewed indicated that all staff had completed mandatory training.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were required to the governance and management arrangements to ensure effective oversight of safeguarding incidents and to ensure that the standardised assessment of need process 'My support needs assessment' had not been completed in line with the regulatory plan submitted to the Chief Inspector.

- A recent incident reported to the Chief Inspector had not been managed or investigated in line with the safeguarding policy in a timely manner. Preliminary screening did not take place within the time lines set out in the providers own safeguarding policy. The inspector was also informed of lengthy delays in requesting and obtaining statements from staff leading to undue delays into the investigation and resulting outcome.
- The provider had failed to submit updates to provide assurances that previous safeguarding incidents had been managed in line with the safeguarding policy. At the time of the previous inspection, there were a number of safeguarding incidents under investigation. The senior management team undertook to submit updates to the Chief Inspector regarding the progress and outcomes of these investigations, however, these updates were not submitted.
- Information of concern was received by the office of the Chief Inspector indicating that families had not been updated and provided with full investigation reports following alleged safeguarding incidents in the past.
- The inspector was not assured that the provider had adequate polices, procedures and guidance available to staff to ensure that residents finances were adequately safeguarded.

The new standardised assessment of need process 'My support needs assessment' had not been completed in line with the regulatory plan submitted to the Chief Inspector. The person in charge confirmed that the partial assessments completed to date were not informative, did not identify the type of supports required, the staff

skill set or the staff training needs to support the needs of residents. To date the residents and or their representatives had not been consulted with as part of the assessment process.

Judgment: Not compliant

Quality and safety

The local management team and staff strived to ensure that residents received an individualised, safe and good quality service. The residents spoken with stated that they liked living in the centre, appeared to be content and relaxed in their environment and with staff supporting them. Staff knew the residents well, were familiar with and knowledgeable regarding their up-to-date assessed health and social care needs and the individual recommendations of allied health professionals. Residents had lived together for a long number of years and got on well with one another.

The provider informed the Chief inspector in its service improvement plan that it was going to complete a full reassessment of all residents needs using a new standardised needs assessment template. The provider outlined a multi-stage process to be completed by September 2023. The assessment had not followed the process as outlined by the provider in so far as there was no input to date from the residents or their representatives. The person in charge spoke of this new template 'My support needs assessment', part of which had been completed and submitted to the senior management team. The local management team could not explain or interpret the outcome of the stage one assessment.

The person in charge advised that 'My all about me' assessment was still being used to inform the support needs of residents.The inspector reviewed a sample of residents files and noted that this assessment had been recently reviewed and updated. A range of up-to-date risk assessments were also completed including risk of developing pressure ulcers, falls risk, swallow assessment, moving and handling and restrictive measures in use. Care plans were found to be recently reviewed, informative, individualised and person centered. Residents who required supports with communication had comprehensive plans in place which were tailored to their individual communication preferences and support needs.

Residents' nutritional needs were assessed, their weights were monitored regularly and plans of care had been developed as required based on these assessments and monitoring outcomes. The recommendations of the speech and language therapist (SALT) provided detailed feeding, eating and drinking guidelines for residents who required a modified consistency diet. Staff had received training and were knowledgeable regarding this guidance and were observed implementing it in practice. Where there was a concern regarding weight loss, a resident had been referred to the GP and prescribed nutritional supplements.

A resident assessed as being at risk of developing pressure ulcers had a specific skin integrity support plan in place. Staff were vigilant and carried out and recorded twice daily skin integrity checks. Staff completed and recorded three hourly repositioning of the resident. Some staff had completed training in relation to skin integrity and staff had access to a nurse within the organisation for advice or to complete wound dressings if required. Staff confirmed that the residents skin was intact at the time of inspection. Suitable specialised equipment including a bed, pressure relieving mattress, specialist cushion and chair had been provided following consultation, assessment and recommendation from the occupational therapist. Staff completed daily checks to ensure the correct settings on the specialised mattress.

Residents assessed as being at high risk of falls were being supervised closely by staff. An environmental safety checklist had been completed as part of the falls prevention strategy. The physiotherapist had assessed residents and they had individual physiotherapy programmes in place. Residents who required specialised foot wear had been assessed and appropriate footwear provided.

Residents' had regular and timely access to general practitioners (GPs) including out of hours service and to health and social care professionals. A review of residents files showed that residents had been referred and recently reviewed by a range of allied health professionals and consultants. Residents recently had their annual medical reviews. Some residents had been recently seen by the physiotherapist, occupational therapist, chiropodist, dentist and footwear specialist. Others were referred and waiting on assessments and appointments for dermatology, ophthalmology and gerontology. Residents were supported to access vaccination programmes. Residents had availed of the COVID-19 and influenza vaccine programmes. Each resident had an up-to-date hospital passport which included important and useful information specific to each resident in the event of they requiring hospital admission.

Personal plans had been developed in consultation with residents, family members and staff. Review meetings took place annually, at which residents' personal goals and support needs for the coming year were discussed and documented. While individual goals were outlined along with the names of those responsible for supporting each resident achieve the goals in the plan within agreed timescales, some improvements were required to ensure that all goals outlined in the plan were meaningful and appropriate. The person in charge advised that they had discussed meaningful goal planning with some staff and that the provider had planned to provide training for all staff in person centered personal planning processes. A template was maintained to show progress and achievement of each goal. From a review of these logs the inspector was clearly able to see that many of the goals outlined had been achieved and others were planned or in progress.

There was evidence of regular and ongoing review of risk in the centre. The person in charge and team leader had completed a training workshop on risk management and training was scheduled for all staff in August 2023. The person in charge outlined the risk escalation pathways and confirmed that the top five centre risks were discussed regularly with the senior manager and at the monthly team meetings. Minutes of recent staff meetings reviewed showed that these risks had

been discussed. The health care needs of residents, behaviour that challenged, restrictive practices, service user compatibility and manual handling were identified as the main risks in the centre at the time of inspection.

Regulation 26: Risk management procedures

There were systems in place for the identification and on-going review of risk. The risk register was reflective of identified risk in the centre. The individual risks to residents were clearly outlined in each file. The person in charge was clearly able to outline the 'out of hours' emergency on-call system that had been introduced by the provider in recent months. The person in charge and team leader had recently completed a training workshop on risk management and training was scheduled for all staff in August 2023.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge continued to review and update the 'All about me' needs assessment. Support plans were in place for all identified issues including specific health care needs and were found to be individualised and informative. All residents had an annual medical review completed, they had access to a range of allied health services as required. Residents with specific health care needs had regular review by specialist consultants.

Improvements were required to ensure that all goals outlined in the personal plans were meaningful and appropriate. The person in charge advised that they had discussed meaningful goal planning with some staff and that the provider had planned to provide training for all staff in person centered personal planning processes.

'My support needs assessment' the new standardised assessment of need process had not been completed in line with the regulatory plan submitted to the Chief Inspector has been included as an action under Regulation 23:Governance and management .

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant

Compliance Plan for Seacrest Services OSV-0001509

Inspection ID: MON-0041186

Date of inspection: 16/08/2023

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider acknowledges that there was procedural non compliances in a recent safeguarding investigation and this had not been managed in line with the organisational policy. As a result of this recent procedural non compliance , the provider has commissioned an external review of the organisational policy and procedure on Safeguarding and Trust in care and this external review will be completed by 30th November 2023 .

Updates on previous safeguarding incidents have been provided to the Chief Inspector and all notifications have been closed .
Families have been updated and provided with the outcome of safeguarding investigations.
Safeguarding training will be completed with all staff in Seacrest by 30th October 2023
The Person in charge will review all incidents to include safeguarding incidents as and when they occur to identify trends, evidence or other indicators that a review of risk or resident's needs assessment is required. The Area Service Manager will review all incidents including safeguarding incidents as part of the monthly service review with the person in charge.

The Policy and procedure for service users personal finance and property is currently being reviewed and updated and this will be completed by 30th October 2023.
My All About Me Assessment document is an existing Ability West document which is completed by the Person in Charge and the Keyworker, it can be located in the personal plans for the purpose of review. This assessment is completed in conjunction with the resident and reflects their wishes.
The Person in Charge will ensure that this document is regularly reviewed when an emerging/ changing need is identified.

My Support Needs Assessment has been completed by the Person in Charge and a member from the MDT. This document is stage one of a Provider needs assessment to inform current and future needs for each Resident in Ability West. This is as per the updated HIQA regulatory compliance plan dated 13th September 2023.

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:
The person in charge is responsible for ensuring that residents' assessments of needs are up to date and accurate.

My All About Me Assessment document is an existing Ability West document which is completed by the Person in Charge and the Keyworker, it can be located in the personal plans for the purpose of review. This assessment is completed in conjunction with the resident and reflects their wishes.
The Person in Charge will ensure that this document is regularly reviewed when an emerging/ changing need is identified.

My Support Needs Assessment has been completed by the Person in Charge and a member from the MDT. This document is stage one of a Provider needs assessment to inform current and future needs for each Resident in Ability West. This is as per the updated HIQA regulatory compliance plan dated 13th September 2023.
The Person in Charge will meet with staff monthly and discuss the progress of each residents goals. The provider will provide staff training in Person Centered Planning by 30th November 2023. Key-working and goal planning will be added to the staff supervision schedule, team meeting minutes agenda and staff competency document , completed by 16th August 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.	Not Compliant	Orange	30/11/2023
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/11/2023
Regulation 05(4)(c)	The person in charge shall, no	Substantially Compliant	Yellow	30/11/2023

	later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident’s wishes, age and the nature of his or her disability.			