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

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|---|---|
| Name of designated centre: | Teach Rua |
| Name of provider: | The Rehab Group |
| Address of centre: | Clare |
| Type of inspection: | Announced |
| Date of inspection: | 09 January 2024 |
| Centre ID: | OSV-0007972 |
| Fieldwork ID: | MON-0032486 |

## About the designated centre

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

Teach Rua is a designated centre run by The Rehab Group. The centre is registered to provide accommodation for a maximum of three residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of one two-storey building on its own spacious site located a few kilometres from a busy town in Co. Clare. Residents are provided with their own bedroom, some en-suite facilities, shared bathrooms, a main sitting room, kitchen and dining area and a relaxation room. A staff office and a staff bedroom are also provided. Residents have access to a spacious rear garden where recreational equipment suited to their age and needs is provided. Staff are on duty both day and night to support the residents who live in this centre. Management and oversight of the service is delegated to the person in charge supported by a team leader.

**The following information outlines some additional data on this centre.**

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| 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 | 10:00hrs to 17:00hrs | Mary Moore | Lead |

## What residents told us and what inspectors observed

This inspection was undertaken on behalf of the Chief Inspector to monitor the provider's compliance with the regulations and the standards. The provider had applied to the Chief Inspector to renew the registration of this centre. Overall, the inspector found good practice and a commitment to provide each resident with a good service. However, the provider had and was experiencing challenges to consistently maintaining the staffing levels residents needed. This was impacting on the quality of the service. Improvement was also needed in other areas such as risk management and the use and on-going minimisation of restrictive practices.

Two residents lived in this designated centre and both residents attended an off-site day service operated by the provider Monday to Friday. When the inspector arrived at the centre one resident had left for their day service and the other resident was in the process of leaving. Ordinarily, the centre is not staffed when the residents are at their day service. The local management team comprised of the regional manager, the incoming person in charge and the team leader were on site and facilitated this inspection.

The inspector found the management team to be well informed of the needs of the residents and they could clearly describe the overall administration and oversight of the service and challenges arising such as the staffing challenges mentioned above. The provider was effectively utilising its quality assurance systems such as the annual service review to monitor the service. Monitoring included seeking and receiving feedback from residents' representatives. Overall, the feedback on file was positive but representatives also felt free to raise matters that they believed could be improved. For example, the turnover of staff had been raised by a representative. The provider listened to such feedback and maintained a record of the assurances and actions that it took in response to this feedback and formal complaints.

Both residents had regular access to home supported by staff members as necessary and family were free to call to the house.

Overall, the house provided residents with a safe and comfortable home. The house presented as visibly clean and in general it was well maintained. However, the needs and abilities of each resident were different and there were arrangements such as environmental restrictions that were in place for one resident but impacted on the other. The provider recognised this and sought to minimise the impact. In response to these inspection findings, the provider made the proactive decision to reduce the number of residents that could be accommodated in the service.

There were good arrangements in place for promoting and meeting residents' healthcare needs and residents had access to the services that they needed. The provider was responsive to any concerns that arose about the safety of the care and

support that residents received.

The inspector had the opportunity to meet with both residents and the frontline staff team when they returned in the evening from the day service. The assessed needs of both residents included communication differences and residents did not provide explicit feedback on their experience of living in this centre. However, the inspector noted that both residents presented as very comfortable with the staff members on duty as they sought out staff, were happy to sit with staff and spend time in the kitchen as staff prepared the evening meal. The staff team introduced the inspector to each resident and both residents made good but brief eye contact with the inspector and gently took the inspectors hand in greeting. The inspector saw how one resident accessed the key needed to unlock a kitchen cupboard and choose a snack for themselves from the cupboard with support from staff. The resident was also noted to access and use the fob to release the keypad on their bedroom door. Residents were noted to not interact with each other or to be greatly interested in what the other was doing. For example, one resident was happy engaging with their magazines and personal computer device. The other resident was content to sit in the kitchen and enjoy their snack. Management and staff confirmed that residents largely had separate routines.

The staff team had completed human rights training. The staff members on duty were noted to be attentive to both residents and observed to be empathetic to the particular needs of one resident on the day of this inspection as they discussed and described the support that would be provided. Management confirmed that they would be available as needed if additional support or advice was needed.

In summary, this was a good person-centred service but the appropriateness and quality of the service was constrained by the provider's inability to consistently maintain the staffing levels that residents needed. The provider had made efforts to recruit staff to address this. Insufficient staffing meant that safe community access for residents could not always be facilitated. This impacted on the choice and range of opportunities that staff could afford to residents.

The next two sections of this report will discuss the governance and management arrangements in place and how these impacted on the quality and safety of the service provided to residents.

## Capacity and capability

The management structure was clear. Responsibility for the day-to-day management of the service was delegated to a person in charge supported by a team leader. Oversight of local management systems was maintained by a regional manager. There had been and there were changes occurring to this structure. For example, there was a change in the person in charge role in progress at the time of this inspection. However, there was evidence of management continuity and clarity

on roles and responsibilities.

For example, the team leader could clearly describe their role and was satisfied they were supported to complete their supervisory and administration duties. The incoming person in charge was known to the organisation and familiar with the provider's policies and procedures and the process of regulation. It was evident that the regional manager was engaged in the management and oversight of the service. For example, the regional manager discussed how they were actively managing and seeking to resolve an open complaint. The regional manager had also completed the annual service review for 2022.

This review and the quality and safety reviews required by the regulations to be completed on a six-monthly basis were completed on schedule. As discussed in the first section of this report the reviews provided for consultation with representatives. Given the assessed needs of the residents, auditors observed residents in their home, their interactions with staff, spoke to staff members to establish their knowledge of residents' supports and gave staff opportunity to raise concerns if they had any. The inspector found the lines of enquiry used were comprehensive, meaningful and specific to the service. Failings and challenges were identified as were the actions taken by the provider to resolve these and to support the service.

For example, the audits highlighted the challenge to maintaining the staffing levels needed. The inspector was advised that the provider had unsuccessfully sought to recruit staff and further recruitment was imminently scheduled. The team leader who prepared the staff duty rota described how they sought to plan the rota so as to minimise the impact on residents. For example, maximising staff levels at the weekends when residents were not at their day service and did not have a planned visit to home. However, the inspector's review of the staff duty rota confirmed that the staffing level of three staff members on duty to facilitate support in the house and in the community was not consistently maintained.

Good oversight was maintained of staff attendance at mandatory, required and desired training. There was a schedule in place for completing formal staff supervisions.

## Regulation 15: Staffing

The provider understood that residents needed continuity of support and care and the staff rota indicated that this was provided for as far as was possible. However, there had been some turnover of staff largely due to planned absence and there were staff vacancies that the provider was actively recruiting for. Minimum staffing levels were maintained and there were always two staff members of staff on duty. However, the deficit in staffing meant that the provider could not consistently ensure the 2:1 staffing ratio required by residents so that they could safely access the community in the evening and at the weekends. This was confirmed by management and was evident from the inspectors review of the staff duty rota and other records such as the daily narrative notes completed by staff. The inspector

reviewed recent staff entries where staff had recorded that they could not offer or facilitate safe community access for the residents due to minimum staffing levels. The impact of this was exacerbated by the difference in residents' needs and their associated risks. Residents did not travel together in the service vehicle and generally led different routines meaning a minimum of three staff were needed to adequately support both residents. A personal plan highlighted the importance of plans, activities and transport options. Insufficient staffing limited consistent adherence to the plan.

Judgment: Not compliant

## Regulation 16: Training and staff development

Staff had access to a programme of staff training that included training in safeguarding, fire safety, responding to behaviour that challenged and, medicines management. Additional training completed by staff included a range of infection prevention and control topics and training on promoting and protecting residents' rights. The inspector requested a representative sample of staff training records to review and found that all mandatory and required training was complete. The provider operated a formal supervision system for all grades of staff. For example, the person in charge facilitated supervision with the team leader who completed supervision with the front-line staff team.

Judgment: Compliant

## Regulation 21: Records

Any of the records requested by the inspector were available. For example, records of each residents on-going medical assessment, treatment and care, details of communication needs and supports, any complaints received and, a record of each fire drill and testing of fire safety equipment. The records were well maintained.

Judgment: Compliant

## Regulation 22: Insurance

The provider submitted, with its application seeking renewal of the registration of this service, evidence that it had in place appropriate insurance such as against injury to residents.

Judgment: Compliant

## Regulation 23: Governance and management

While this inspection identified areas for improvement this was a well managed service where the provider kept good oversight of the effectiveness of the local systems of management. In general, the provider was effectively collecting data about the quality and safety of the service and set out the quality improvement plans needed to address failings it identified. For example, the provider was actively seeking to recruit staff. While there was turnover in the management team this inspection did not identify any concerns in relation to a lack of continuity in management and oversight. For example, the team leader was completing their weekly formal oversight, the annual review and the quality and safety reviews to be completed at least every six months were all completed on schedule. There was clarity on roles and responsibilities such as in responding to complaints and safeguarding concerns. There was some fragmentation between systems of review such as between the monitoring of the impact of staffing deficits, the findings of the analysis of incidents and, how risk was identified and managed. This is addressed in the individual regulations.

Judgment: Compliant

## Regulation 3: Statement of purpose

The provider maintained a statement of purpose and function that contained all of the required information and that accurately described the service. For example, the range of needs that could be met, details of the governance and management arrangements and, how to make a complaint.

Judgment: Compliant

## Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The provider had notified the Chief Inspector of the change in the role of person in charge and of the arrangements in place for the management of the service including the appointment of a new person in charge.

Judgment: Compliant

## Regulation 34: Complaints procedure

The provider had a complaints policy and procedure that was in date and provided guidance on how to make a complaint, described how complaints were investigated and, advised complainants of what they could do if they were dissatisfied with the outcome of their complaint. There was one open complaint. The regional manager described the channels of communication opened with the complainant including discussion of the proposed resolution.

Judgment: Compliant

## Quality and safety

This was a good person centred service. However, as discussed in the previous two sections of this report staffing challenges limited the choice and opportunity that residents had for safe and meaningful community access. With the appropriate staffing levels there was scope to develop and meaningfully progress residents' personal goals and objectives. Based on these inspection findings some improvement was also needed in the systems for identifying and managing risk and in the use of restrictive practices.

The inspector reviewed one personal plan. The plan set out the resident's needs and abilities and the support needed to promote the best possible outcomes for the resident. For example, the plan detailed the resident's specific communication needs, the vocabulary used by the resident, its meaning and how it should be interpreted by staff. It was evident from the plan and discussions with the team leader that resident wellbeing was monitored and, the care and support provided was informed by input from the wider multi-disciplinary team (MDT) such as each resident's general practitioner (GP), psychiatry and positive behaviour support. The plan was updated to include any changing needs.

However, while the personal plan included a number of personal goals and objectives with regard to maximising the resident's personal development, tracking of the progress and achievement or not of these goals was not satisfactory. For example, one goal was for the resident to enjoy a trip to the zoo. Records didn't confirm whether this was achieved or not; the team leader confirmed that it was not achieved.

While of a similar age profile residents had, in the context of their disability, different needs and abilities. The provider had made adjustments to the physical environment in response to incidents that had occurred. One resident had relocated to an upstairs bedroom and had been provided with a fob that they could operate to open their bedroom door. There were a range of environmental restrictions in use in response to risks identified to the safety of both residents. However, there were

restrictions that were in place for the safety of one resident and not required for the safety of the other such as locked food presses and restricted access to the remote controls for the televisions. It was evident that the provider sought to mitigate the impact of restrictions and to reduce restrictions. However, there was some inconsistency in the identification of restrictive practice, plans to reduce restrictions required more structure and, it was evident from records seen that some restrictions were a source of conflict and a trigger for behaviour of concern.

The provider maintained a comprehensive range of risk assessments setting out risks that had been identified and how these risks were controlled. For example, there were work related risk assessments and risk assessments as they pertained to the needs of each resident. However, better correlation was needed between systems for the assessment and management of risk and other systems such as the centres staffing arrangements and, systems that analysed accidents and incidents that occurred such as the detailed analysis completed by the behaviour support team.

Overall, good oversight was maintained of the services fire safety arrangements. For example, there was documentary evidence that equipment such as the fire detection and alarm system was inspected and tested at the appropriate intervals. The provider demonstrated through regular simulated evacuation drills that it had suitable arrangements for evacuating residents and staff. However, there was scope to review how these drills were scheduled so that they maximised the participation of all staff working in the service.

## Regulation 11: Visits

Both residents had regular access to home and family supported if needed by the staff team. Family were also free to visit the centre and privacy for a visit could be provided if needed or requested.

Judgment: Compliant

## Regulation 17: Premises

Residents were provided with a comfortable home. On visual inspection the house was clean and well maintained. Residents had access to a spacious secure rear garden with evidence of recreational equipment that could be used weather permitting. Given the difference in residents needs and abilities the provider had made some adjustments to the layout of the premises. One resident had relocated to an upstairs bedroom and had been provided with fob access to better assure the privacy and security of their personal space and possessions. However, the assessed risks and sensory needs of one resident meant that there was a sparseness to areas

of the house and a high reliance on environmental restrictions. For example, there were reported sensory challenges to displaying items on the walls and items such as remote controls were not freely available. On consideration of these inspection findings and the challenge of assuring compatibility of resident needs for the existing residents and any possible new resident, the provider made the proactive decision to reduce the number of residents that could be accommodated in the house.

Judgment: Compliant

## Regulation 18: Food and nutrition

Residents were offered a range of meals and snacks based on their expressed preferences. Staff monitored the meals that residents liked and did not like and based the menu on what residents had communicated about the meals provided. Staff maintained a record of the meals and snacks provided and these records demonstrated good variety and consideration of nutritional quality. Dietetic advice was sought to inform nutritional plans and staff maintained regular oversight of resident body weight to monitor the effectiveness of the plan.

Judgment: Compliant

## Regulation 20: Information for residents

The provider produced a guide for residents that contained all of the required information such as the terms of residency, how residents would be consulted with, how to make a complaint and, the arrangements for receiving visitors.

Judgment: Compliant

## Regulation 26: Risk management procedures

The provider maintained a comprehensive suite of risk assessments that largely reflected the risks that presented in the centre and how they were controlled. For example, the use of environmental restrictions. It was documented that the risks and the controls were regularly reviewed. There were also systems for the review and analysis of accidents and incidents that occurred. However, the link between these two systems was not clearly evidenced. For example, it was not evident how the findings from the analysis of incidents such as behaviour related incidents were used in the review of risks and their control. A better link was needed between the

review of incidents and other arrangements so as to better capture for example the possible impact of staffing levels and the unintended negative impact of controls such as the restrictions in place.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

The house was fitted with a fire detection and alarm system, emergency lighting and doors with self-closing devices designed to contain fire and protect escape routes. The provider demonstrated that the service could be effectively evacuated. However, there was scope to improve how simulated evacuation drills were scheduled so as to ensure that all staff working in the service had the opportunity to participate in a drill. The majority, but not all staff currently working in the service had participated in the drills completed in 2023.

Judgment: Substantially compliant

## Regulation 29: Medicines and pharmaceutical services

There were systems that supported the safe management of medicines. Medicines were supplied for each resident by a local pharmacist who also generated the medication administration sheet used by staff to record each medicine they administered. Staff administered medicines following an assessment of risk and resident capacity. Medicines were securely stored. The monitoring of resident health and wellbeing included the review of the effectiveness of their prescribed medicines including monitoring for any possible side effects.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

The personal plan included the resident's personal goals and objectives. However, progress of these goals and whether they were achieved or not was not adequately demonstrated. Staff confirmed that one goal queried by the inspector which was a planned trip to a zoo had not been achieved. Possible obstacles to achieving these goals such as new and changing needs or insufficient staffing levels were not recorded. The current staffing deficits meant that there were limitations to what staff could achieve with and for residents. In addition, where a goal had been achieved the learning from this was not used to build on and develop the resident's

positive response to the goal. In general, the nature and range of the chosen goals required review to ensure they had purpose and maximised the resident's general welfare and development.

Judgment: Substantially compliant

## Regulation 6: Health care

Staff monitored resident health and wellbeing and the provider ensured that residents had access to the clinicians and services that they needed. Each resident had their choice of GP and were supported by staff to attend for medical assessment and care as needed. Families were advised of any changes in needs and plans of care. There were times when residents may not have fully understood the need for and the importance of particular interventions. They received the support that they needed so that such treatment was facilitated.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The assessed needs of both residents included a risk for behaviour that challenged. Arrangements were in place that included review and input from the positive behaviour support team and psychiatry. The behaviour that presented, possible triggers and the support to be provided was outlined in an up-to date positive behavioural support plan. The required training was provided for the staff team. A range of environmental restrictions were in place in response to the assessed needs and risks of both residents. The provider had systems for overseeing these restrictions. However, there were restrictions that were necessary only for one resident but impacted on the other resident such as restricted access to foods and restricted access to items such as remote controls. The provider did attempt to reduce this impact. However, the reality was that one resident lived in an environment that had restrictions that they did not need and additional work was needed to see if these restrictions could be safely reduced. For example, the first phase of one restriction reduction plan had been successful but had not been developed further. It was also evident from records seen such as the analysis of incidents that had occurred that restrictions could be and were at times a source for conflict and a trigger for behaviour. For example, restricted access to foodstuffs and the television remote control. Therefore, while designed to manage one risk they had the potential to create another and this was something that required further exploration by the provider. It was also possible based on these inspection findings that all restrictive practice was not recognised and identified. For example, restricting both residents access to a personal care item, how resident access to their personal computer was managed, redirecting a resident from the stairs and,

the inability to consistently facilitate community access.

Judgment: Substantially compliant

## Regulation 8: Protection

The provider had safeguarding policies and procedures and all staff had completed safeguarding training. The staff team discussed staying safe with residents using social stories but there were recognised limitations to residents engagement with these and their understanding of self-care and protection. The regional manager was the designated safeguarding officer and discussed with the inspector how residents were protected by the implementation of the providers safeguarding procedures. Links had been established with the local safeguarding and protection team who had visited the service.

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 | Not compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Teach Rua OSV-0007972

## Inspection ID: MON-0032486

## 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 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>• One 35 hour Care Worker post has been filled. This staff member commenced working in the service on 05/02/2024.<br>• Two 35 hour Care Worker posts have been advertised, closing date for applications was 31/01/2024, interviews scheduled for the week ending 18/02/2024.<br>• Two 35 hour Care Worker vacant posts are currently in recruitment approval process, due to be advertised 29.02.2024<br>• One staff member is due back from long term leave in March 2024. Two additional staff members are due back from maternity leave in July 2024. | |
| Regulation 26: Risk management procedures | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>• Quarterly incident/risk review with Behaviour Therapist (BT), Regional Manager (RM) and PIC to commence February 2024. These reviews will feed into existing/new risk assessments as appropriate.<br><br>• Full review of restrictive practices will be completed by the Team Leader, PIC, BT and RM before 09/04/24.<br><br>• Residents risk assessments have been updated to reflect the impact of low staffing levels on resident's ability to safely access community activities and exercise choice.<br><br>• BT to complete compatibility assessments by 09/04/2024, recommendations arising will | |

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| be implemented as required |

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| Regulation 28: Fire precautions | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Team Leader to schedule Fire Drills to ensure all staff are facilitated to participate in a fire drill at minimum once per year. PIC to review fire drills as per PIC monthly audit.

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| 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:
• PIC and TL have reviewed current action plans with Keyworkers. TL will review action plans weekly as part of Team Leader audit to ensure progress/barriers are captured. PIC to review monthly as part of the PIC monthly audit.

• PCP meetings scheduled for February to support residents to identify future short, medium and long term goals for 2024.

• PIC/TL discussed goals, objectives and action plans with staff team at staff meeting 30.01.2024. Keyworkers to review support plan and action plans following PCP meetings. This will be completed by 01/04/2024.

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| Regulation 7: Positive behavioural support | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• BT attended staff meeting 30/01/2024, reviewed behaviour support plans and reactive strategies with staff team.

• Full review of restrictive practices to take place with TL, PIC, BT and RM will be completed by 09/04/ 2024

• Personal Care item identified in the report is accessible to both residents, this was actioned immediately after the inspection.  Discussed at staff meeting on 30/01/2024.

• Access to personal computer reviewed, resident has full access to personal computer.

• Risk assessment in place to highlight the impact low staffing levels have on the residents.

• Residents guide will be updated and provided for residents in an age appropriate format.  This will be completed by 29/02/2024.

## 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 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 | 31/07/2024 |
| Regulation 26(1)(e) | The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures | Substantially Compliant | Yellow | 09/04/2024 |

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| | might have on the resident's quality of life have been considered. | | | |
| 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 | 09/04/2024 |
| Regulation 28(4)(b) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Substantially Compliant | Yellow | 01/06/2024 |
| Regulation 05(4)(b) | The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with | Substantially Compliant | Yellow | 01/04/2024 |

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| | his or her wishes. | | | |
| Regulation 05(7)(c) | The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales. | Substantially Compliant | Yellow | 01/04/2024 |
| Regulation 07(3) | The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process. | Substantially Compliant | Yellow | 09/04/2024 |
| Regulation 7(5)(a) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour. | Substantially Compliant | Yellow | 09/04/2024 |