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:	Hazel Lodge
Name of provider:	Terra Glen Residential Care Services Limited
Address of centre:	Wexford
Type of inspection:	Announced
Date of inspection:	28 August 2024
Centre ID:	OSV-0008104
Fieldwork ID:	MON-0035779

About the designated centre

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

This centre comprises a large detached property in a rural area in County Wexford. The centre is registered for a maximum of three individuals over the age of 18 years and is currently home to three residents. The centre comprises a kitchen and dining area, sitting room, staff office and three registered en-suite bedrooms with an additional bedroom for staff use. There is a large garden running around the property currently set to lawn with a patio area accessed from the kitchen. The centre is staffed at all times when a resident is present and the staff team is made up of a person in charge, deputy manager, two shift leads and a team of social care workers. The provider states that their aim is to provide a home from home while supporting all individuals who live in the centre to reach their full potential.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 28 August 2024	09:30hrs to 15:00hrs	Tanya Brady	Lead
Wednesday 28 August 2024	09:30hrs to 15:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

This was an announced inspection completed to inform a decision about the renewal of the centre registration. The provider had submitted an application to review registration in advance of this inspection which was completed by two inspectors over the course of one day.

This centre is a detached house set within a large garden in a rural setting in Co Wexford. All residents have their own bedrooms which are en-suite and two bedrooms also have walk-in wardrobe areas. There is an additional bathroom and a staff bedroom upstairs. Downstairs the property has a sitting room, staff office, kitchen-dining room and sun-room. In addition residents can access a utility room, downstairs toilet and smaller office space. Outside the property has ample parking to the front, a patio to the rear and large area set to lawn.

The centre is registered for a maximum of three adults and is currently at full capacity. The inspectors had the opportunity to meet with all three individuals who live here over the course of the day. The three residents all told inspectors that they liked living in the centre and that they were happy here. The inspectors also met with the person in charge, a senior manager and the staff team over the course of the day.

The inspectors had reviewed submitted information in advance of the inspection that included the provider's annual report on the quality and safety of care and support and information submitted as required via the notifications process. The information submitted to the Chief Inspector of social services had outlined some peer to peer incompatibility concerns within the centre and some safeguarding concerns. In addition there had been information submitted relating to two residents who separately had been missing for periods of time from the centre without staff support in addition to information of concern related to residents engagement with others via social media platforms. All of these incidents were reviewed by inspectors in detail on the day of inspection.

On arrival inspectors were greeted by one resident who welcomed them to their home and asked to review inspectors identification. The resident was supported by a staff member and explained that they had known the inspectors were visiting. They outlined their plans for the day and asked for clarification about the purpose of the inspection. This resident was supported to leave the centre a number of times over the day to go out and engage in activities they had chosen to be involved in. They explained they were happy and that life was good at the moment. The resident had recently been away on holidays with family and spoke about activities they enjoyed. They explained what they did if they had worries or concerns they said they would feel comfortable talking to any member of the staff team and said that they enjoy staff company.

A number of times during the inspection, the inspectors observed residents spending

time with staff in the kitchen-dining come sun room. They were chatting, laughing, planning their day, preparing food and looking at television.. Residents spoke with the inspectors about their hobbies and interests. They spoke about day services they had attended, spending time with their family and friends, how they liked to take part in the upkeep of their home, going shopping, making videos and dancing group. There were games, televisions, and arts and crafts supplies available in the house.

A second resident was in their bedroom when inspectors arrived getting ready for their day. When they came downstairs they joined the inspectors and a staff member sitting in the sun room and explained that they were going shopping with staff. They showed one inspector their bedroom and explained that they had only recently moved into the centre and were getting the room decorated as they wished. They talked about the posters they had on the walls and their love of a particular pop culture which was reflected in the decor.

The third resident was also in their bedroom and came down later in the day to meet inspectors. They spoke to inspectors and stated that this centre was the best placement they ever had and named the person in charge as someone that they had a very good rapport with. The resident said they enjoyed living in the centre but one day would like to live independently. The resident spent much of the inspection day in their room although they were observed later chatting with staff in the kitchen.

Residents were complimentary towards the staff team. Throughout the inspection, warm, kind and caring interactions were observed between residents and staff. Resident meetings were being held and residents were meeting with their keyworkers regularly. There was information available in the house in an easy-to-read format on areas such as, safeguarding, advocacy, human rights, infection prevention and control (IPC), and complaints.

In summary, from what residents told them, what the inspectors observed and from reviewing documentation, it was evident that residents in the centre were well-supported, staying in regular contact with their family and friends and pursuing meaningful activities in their local community. They were supported by a staff team who they were familiar with and the provider was aware of the areas where improvements were required and taking the required steps to address these. Improvements were required however, in the consistent implementation of control measures when managing risk and in ensuring all residents were safe at all times. In addition improvement was required in ensuring that the assessed needs for all residents were safely managed. These are discussed in detail under the specific Regulations below.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre. The newly appointed person in charge facilitated the inspection. The Provider's director of disability services also attended and was present for feedback at the end of the inspection.

This centre had been inspected on two occasions in 2023 when the centre had poor compliance with the Regulations and there were significant peer to peer safeguarding concerns and risks identified.

The findings from the current inspection indicated that the centre had implemented the majority of actions that the provider had identified and was well-managed and generally in compliance with the Regulations reviewed. There were various oversight strategies which were found to be effective both in relation to monitoring practices, and in quality improvement in various areas of care and support. Improvements were required however, in the management of risk within the centre and in individualised assessment and personal plan development. Findings in these areas are addressed under Regulation 26 and Regulation 5 below.

Registration Regulation 5: Application for registration or renewal of registration

The inspectors reviewed information submitted by the provider with the application to renew the registration of the designated centre and found that they had submitted the required information.

Judgment: Compliant

Regulation 14: Persons in charge

A new person in charge had been appointed by the provider shortly before the inspection. The provider had ensured that the person in charge had been appointed to work full-time and that they held the necessary skills and qualifications to carry out their role.

The residents were observed to be very familiar with them and appeared very comfortable and content in their presence. The residents laughed and smiled as they spoke to, and about the person in charge. The staff members who spoke with the inspectors were also complimentary towards the support they provided to them.

The person in charge demonstrated their knowledge of the regulations and accessed all documentation requested during the inspection by the inspectors in a timely manner. The person in charge was self-identifying areas for improvement and had implemented the required actions to bring about these improvements. They had a clear focus on quality improvement initiatives and were very motivated to ensure the residents were living a life of their choosing.

The inspectors were informed and saw documented evidence of duties being delegated and shared, including audits, fire safety, staff supervision, and a review of personal plans among senior staff, key workers, and the person in charge.

Judgment: Compliant

Regulation 15: Staffing

The provider ensured that there were suitably qualified, competent and experienced staff on duty to meet residents' current assessed needs. The inspectors observed that the number and skill mix of staff contributed to the positive outcomes observed for residents using the service. Warm, kind and caring interactions were observed between residents and staff.

The centre was staffed in line with the statement of purpose at the time of the inspection with one vacancy that had been recruited for. Two relief staff employed by the provider were used for regular cover and agency staff were only utilised for short term cover such as sick leave. The rosters reviewed showed that a small number of shifts were covered by the same two regular relief staff.

The inspectors reviewed planned and actual rosters from July to August 2024 and found that they were well maintained. Planned rosters for September 2024 were also reviewed.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors reviewed the training records held in the centre. The provider and person in charge were in the process of amalgamating all previous records into a new system which the inspectors reviewed. This allowed for the person in charge to track and review when a staff member may be required to complete refresher training or whether all staff had completed training as required.

From review, all staff employed in the centre had completed mandatory training as

required by the provider's policy. These included fire safety, safeguarding and manual handling for example. The person in charge also maintained a record of training held by agency and relief staff who were on the centre roster.

The inspectors reviewed a sample of staff supervision records. The agenda was resident focused and varied. From the sample reviewed, discussions were held in relation to areas such as staff's roles and responsibilities, training, policies procedures and guidelines, keyworking, team meetings, and staff's strengths and areas for development.

Staff who spoke with the inspectors stated they were well supported and aware of who to raise any concerns they may have in relation to the day-to-day management of centre or the residents' care and support in the centre. They spoke about the provider's on-call system and the availability of the person in charge by phone out-of-hours.

Judgment: Compliant

Regulation 23: Governance and management

There had been a number of recent changes to the local management team. A new person in charge had commenced in their role in recent months. The person in charge was very familiar with the service and the residents, having worked in the centre as a team leader previously. A new team leader was also in post and available on the day of inspection to meet inspectors. The management structure defined in the statement of purpose was in line with those described by staff during the inspection. From a review of the statement of purpose, the minutes of management and staff meetings for 2024, and a review of staff files there were identified lines of authority and accountability amongst the team.

The provider systems to monitor the quality and safety of service provided for the resident included area-specific audits, unannounced provider audits every six months, and an annual review. Through a review of documentation and discussions with staff the inspectors found that provider's systems to monitor the quality and safety of care and support were being fully utilised and proving effective at the time of the inspection. The provider's policies, procedures and guidelines were readily available in the centre to guide staff practice although these were not fully utilised in all areas as outlined for example under Regulation 26.

In addition to the scheduled audits and visits completed by the provider there were unannounced spot audits by a senior manager, peer to peer audits completed by persons in charge also employed by the provider and the person in charge completed a detailed weekly governance report that was reviewed by a senior manager.

Staff meetings were happening in line with the provider's policy and there were daily handovers where staff's roles and responsibilities for each shift were clearly outlined. Some staff had delegated duties and these were being completed and reviewed by the person in charge.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The provider had admissions policies and procedures in place. All residents had individual contracts of care which contained the required information. The contracts clearly outlined fees and costs that may be payable by residents.

Judgment: Compliant

Quality and safety

From what the inspectors observed and were told, and from reviewing documentation, it was evident that residents were in receipt of a good quality service. Some improvement was required as already stated to ensure that residents were in receipt of a safe service at all times.

Residents were being supported by a staff team who they were familiar with and they were engaging in activities of their choice in their home or in their local communities. Residents were being supported to be independent and to be aware of their rights. They were also supported to access information on how to keep themselves safe and well. Residents who wished to, were being supported to access day services or educational opportunities.

Regulation 12: Personal possessions

The provider had policies and procedures in place that provided clear guidance for staff on the management of resident finances. These were found to be clearly implemented for two residents however, some improvement was required to ensure that a third resident was fully safeguarded. This finding is reflected under Regulation 5.

Inspectors reviewed the systems in place to monitor and manage each residents finances. Each resident's finances were found to be secure, accounted for and well protected. Receipts were checked and cross referenced with bank account

statements to ensure residents finances were protected and safeguarded. Residents were encouraged to make sensible decisions regarding spending and budget management and the person in charge showed various examples of where this had occurred.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had ample opportunities to live meaningful lives in this centre. Inspectors saw examples of residents pursuing activities in line with their own preferences such as going shopping, going to matches/sports events, music festivals, dancing, singing, pc/computer workshops, baking/cooking, gym, making videos and going walking/hiking. Some residents did not always want to participate in activities and their choices were respected but inspectors found there was always plenty of social stimulation and activity going on and available to residents in this centre.

Judgment: Compliant

Regulation 17: Premises

The inspectors completed a walk around the premises at different times of the day. One inspector was accompanied by a member of staff and the other inspector later in the day was accompanied by the person in charge. Two residents showed the inspectors their individual bedrooms and talked about what they liked in their rooms.

Externally there was a driveway to the front of the house with ample parking. There was a large garden to the side and rear of the house with equipment such as a trampoline, football goal posts and a tent available to use, in addition there was a patio area outside the back door.

Internally the residents all had large bedrooms with en-suite bathrooms and two residents had spacious walk-in wardrobe areas. Upstairs was an additional bathroom. There was a sitting room which had a newly developed sensory area, a large kitchen-dining room with an adjacent sun room that had double doors out to the garden. Residents had access to a utility/laundry room and there was a staff office on the ground floor.

The house was found to be clean and homely. Overall it was well maintained and there was evidence on the day of inspection of repair and maintenance taking place. Areas of this home were highly personalised and residents had access to private spaces and a number of communal areas. They also had access to sufficient storage for their personal items.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk management policy in place and a risk register and general and individual risk assessments had been completed.

The registered provider had systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies. The inspectors reviewed the risk register and the risk assessments for all residents and found that improvement was required to ensure that they were reflective of the presenting risks and that they provided appropriate guidance for staff.

Inspectors reviewed a number of significant incidents that had been notified to the Chief Inspector and found that in some cases while the incidents had been reviewed there was no clear outcome or learning evidenced. For instance when a resident was independently in the community and travelling to another location there was no guidance for staff on how often to check in with the resident or at what point they should flag a concern if they had not heard from the resident. For example on 01/08/2024 a resident had been contacted at 11:30 however there was no evidence that there had been another contact made until 17:50. This had arisen as staff had no protocol to follow, multiple staff were trying to make contact and no central record was maintained. This was of significance as the following day, the resident was absent from the centre for over five hours in a high risk situation where An Garda Síochána were involved. The situation on both days demonstrated no consistent approach to the management of risk in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors found through the review of each residents' information that improvement was required in the consistent use of appropriate systems for assessing their health and social care needs. For two residents it was apparent that a multi-disciplinary approach had been adopted and implemented. A number of professionals, in conjunction with the person in charge, staff team and the resident had been involved in the completion of detailed assessments of need.Arising from these assessments detailed personal plans had been developed and were in place.

For one resident however, the assessment of their needs had not been completed by a multi-disciplinary team and it was clear from a review of incidents and from a

review of current personal/intimate care challenges, that the personal plans in place were failing to provide for the residents assessed needs.

Inspectors found that this resident required an up to date comprehensive/multidisciplinary care plan review that ensured all aspects of care provision were provided for, in line with centres stated purpose and function and the residents contract of provision of service.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents had access to a behaviour support specialist and they had positive behaviour support plans in place which were reviewed and updated regularly. The inspectors reviewed a sample from the residents' plans and found they were clear and concise and set out communication styles and approaches that best supported the residents. The inspectors found that staff who spoke with them were knowledgeable in relation to the proactive and reactive strategies detailed in the residents' positive behaviour support plans.

There were a small number of physical, environmental and chemical restrictive practices in use. These were recorded and audited in a monthly basis by members of the management team. Inspectors reviewed a sample of rights assessments and restrictive practice assessments associated with these. It was found that some of the strategies were not consistently being implemented and this is reflected under Regulation 26. For example for a resident who may leave staff presence when they are under the pressure a support measure was to call and text to provide reassurance. On all occasions the resident had turned off their phone when in this situation and staff could not implement measures as outlined. These scenarios were not accounted for in risk assessments.

There were easy-to-read documents available for residents on human rights and the use of restrictive practices. The local management team were logging and reviewing them and restrictive practices were reviewed by the provider. The restrictive practices in place on the day of the inspection were in line with those notified to the Chief Inspector on a quarterly basis.

Through discussions with staff and a review of documentation it was clear that alternatives were considered before restrictive practices were used, and that the least restrictive procedure was used for the shortest duration. Restrictive practice reduction plans were developed and implemented, where possible.

Judgment: Compliant

Regulation 9: Residents' rights

Through a review of documentation, and discussions with residents and staff, it was evident that residents were empowered to make choice and decisions about how and where they spent their time. Their opinions were sought on a daily basis in relation to areas such as menu and activity planning.

From a review of resident meetings between February and August 2024 and from records of key working sessions and significant conversations it was evident that they were provided with information on their rights. The minutes of the resident meetings were in an easy-to-read format and there were suggestions of different menu and activities for people to choose from. There was information available on how to access independent advocacy services and this was regularly discussed at resident meetings.

Staff were observed to treat residents with dignity and respect. Their privacy was maintained and they were observed to seek out staff support if and when the needed it.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Hazel Lodge OSV-0008104

Inspection ID: MON-0035779

Date of inspection: 28/08/2024

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 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to meet this regulation in Hazel Lodge management, staff and person we support have collaborated to compile and redevelop the following documents to ensure risk management is the centre of service provision:

• Collaborative Efforts:
- Management, staff, and PWS have worked together to update risk management documents, ensuring a comprehensive approach.

• Emergency Response Guidelines:
- The Person in Charge (PIC) will establish guidelines for staff on responding to emergencies, including:
- Procedures for missing individuals in various scenarios.
- Clear instructions for staff actions in different situations whether in the community or in the house.

• Risk Assessment Updates:
- The absconding risk assessment will be revised to include new protocols.
- Evaluations for independent travel will be paused until mental health stability is confirmed.

• Communication Strategies:
- A communication plan will be created to outline how to engage with individuals during challenging times.
- Logs will be maintained to document interactions in the house and in the community, focusing on transparency and support.

• Missing Person Protocol:
- New protocols will guide staff responses to absences, detailing frequent areas of activity while maintaining confidentiality.

• Implementation of Restrictive Practices:
- Two necessary restrictive practices have been introduced:
-Independent Travel: Monitoring will occur, with reviews scheduled to assess effectiveness and necessity.
- Seating Arrangement in Transport (Back seat): Adjustments have been made to promote safety during transport.
- These will be reviewed after 2 months.

• Proactive Communication Measures:
- A communication log will track all staff interactions, ensuring that support remains consistent and documented.
- Guidelines will ensure adherence to best practices in communication, respecting individual preferences.

• Updated Risk Assessments:
- Risk assessments have been reviewed and updated to address:
- Community engagement
- Personal safety (Personal sharps agreement)
- Co-habitating arrangements
- Absconding risks (missing person guidelines)

• Positive Behavior Support Plan Review:
- The behavior support plan has been reviewed to address specific needs and risks, ensuring a tailored approach to care.

• Collaboration with PWS
- All procedures have been developed in collaboration with PWS to ensure their perspectives and preferences are integrated into risk management practices.
- PWS has been actively involved in discussions regarding restrictive practices, communication strategies, and the development of risk assessments, ensuring that their voice is central to the care provided.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• Multidisciplinary Team Involvement:
- The needs assessment will be revised and updated by a multidisciplinary team, including a behavior specialist, the person in charge, the director of services, and key

workers.

• Consultation Process:
- A meeting will be held to discuss the proposal for the personal plan.
- To avoid overwhelming PWS, their involvement in the meeting will be limited; staff will present changes in small, manageable sessions.

• Personal Intimate Care Contract:
- A contract will be implemented by the person in charge (PIC), focusing on all aspects of personal intimate care.

• Care Plan Updates:
- Current care plans will be updated to reflect the needs of PWS.
- A new "Comprehensive Care Plan" will address care aspects.

• Service User Consultation:
- Staff will consult with PWS to gauge interest in working on personal hygiene as a social goal.

• Collaboration with Professionals:
- The client's psychotherapist will be contacted for insights on supporting personal care.
- A multidisciplinary team (MDT) meeting will be scheduled with all professionals involved in PWS's care.

• Documentation Updates:
• The following documents will be reviewed, updated, or created:
- Assessment of support
- Pre-admission risk assessment
- Safety plan
- Contract for personal intimate care
- Positive behavior support plan
- Relevant risk assessments
- Comprehensive care plan (NEW)
- Personal sharps consent form
- Service user consultation on personal sharps consent form

• Ongoing Communication:
- All professionals will be contacted in advance to arrange a suitable date for meetings and consultations.

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 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	09/10/2024
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 reflect changes in need and circumstances, but no less frequently than on an annual	Not Compliant	Orange	09/10/2024

	basis.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	09/10/2024
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	09/10/2024