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

Issued by the Chief Inspector

Name of designated centre:	Raceview Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	04 January 2023
Centre ID:	OSV-0008242
Fieldwork ID:	MON-0036733

About the designated centre

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

Raceview Services provides a supported accommodation service for four male adults with an intellectual disability who have been identified as requiring minimum to moderate support. The centre comprises of a dormer style two-storey house located in an urban residential area close to a range of amenities and public transport. Each resident has their own bedroom and there is a variety of shared living space. Residents have access to a large garden area and the centre has its own vehicle available for residents to access the community. Residents at Raceview Services are supported by a staff team which includes both social and care staff as well as sleep in staff at night time.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 4 January 2023	09:00hrs to 16:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations. This is a new service which had been registered in April 2022.

On arrival at the centre, staff on duty guided the inspector through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene and face covering.

The inspector met and spoke with staff members on duty, the assistant director of client services and the person in charge. There were four male residents with full-time residential placements, however, some residents were still in the process of transitioning and were not yet living in the centre on a full-time basis. One resident who had been assessed as requiring one to one support currently availed of the service three days a week and stayed overnight on one night during the week. On the day of inspection there were two residents living in the centre and the inspector met and spoke with both.

The house was designed and laid out to meet the number and needs of residents. It had been extensively renovated in early 2022 and was finished to a high standard. It was spacious, bright, visibly clean and furnished in a homely style. There were four large bedrooms, two with en suite shower facilities for residents use. Three of the bedrooms were located on the ground floor and one bedroom was located on the first floor. Bedrooms were decorated and furnished in line with residents individual preferences. Each bedroom had a television, adequate storage space for personal belongings and were personalised with family photographs and other items of significance to each resident. There was an additional bathroom/shower room available on each floor. There were two additional bedrooms available for use by staff. There was a variety of communal day space available including a well equipped kitchen, dining room, two sitting rooms and a conservatory. There was a separate utility room, storage rooms and an external store. Residents had easy access to well maintained mature garden areas. The building was accessible with suitable ramps provided to the front entrance area and adequate car parking spaces provided.

On the morning of the inspection, both residents had already left the house. One of the residents had gone to work and the other had left to attend his regular day service. The inspector met with both residents when they returned to the centre in the afternoon. They were both in good form and appeared content and comfortable in their surroundings. On their return to the house, they relaxed in the kitchen with a cup of tea chatting to staff in a familiar and friendly way about their Christmas holidays and families. They stated that they liked the house, their bedrooms, liked living in the centre, and enjoyed having plenty of space, They said that they enjoyed going to work, attending day services and doing activities that they enjoyed in the evenings and at weekends.

Staff continued to support residents in keeping active and partaking in activities that they enjoyed both in the house and out in the community. Residents decided on and planned their preferred activities at the weekly house meetings but could also decide to choose their preferred activity on a daily basis. Residents enjoyed a variety of activities including bowling, going to the cinema, going for walks, going on day trips, eating out and getting takeaways. One of the residents enjoyed partaking in many sporting activities including basketball, swimming, football and kayaking. He told the inspector how he had also enjoyed a Christmas day swim while at staying at home with his family. Residents' independence was very much promoted. Some residents liked to help out with shopping, cooking, cleaning and laundry. One resident independently used public transport and went about his own routines on a daily basis

There were measures in place to ensure that residents' rights were being upheld. Residents' likes, dislikes, preferences and support needs were gathered through the personal planning process, by regular consultation, by observation and from information supplied by families, and this information was used for personalised activity planning. The inspector observed that the rights of residents were respected and promoted by staff. Residents had access to televisions, the Internet and information technology. There was a range of easy-to-read documents and information supplied to residents in a suitable accessible format. For example, easy-to-read versions of important information such as residents rights, the complaints process, COVID-19 and staffing information were made available to residents. The inspector observed that the privacy and dignity of residents was well respected by staff throughout the inspection. There was evidence of on-going consultation with residents through regular house meetings at which issues such as residents rights, the human rights charter, right to feel safe, anti-bullying, fire safety and how to make a complaint were discussed.

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. Staff spoke of their concerns regarding recent staffing shortages and how they worked additional hours in order to cover the rota. Staff spoken with were also concerned that a resident who required one to one support who was currently staying one night a week could not be facilitated to stay additional nights due to the current staff shortage.

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. Non-compliance's identified in relation to governance and management, staffing, restrictive practices and to the notification of required incidents had the potential to impact negatively on the quality and safety of the service provided.

Capacity and capability

This was the first inspection of this centre since it was registered as a designated centre in April 2022. It was an unannounced inspection carried out to

- monitor compliance with the Regulations
- following notification to a change in the person participating in the management of the centre
- following a recent notification of a change to the person in charge of the centre.

While the local governance and management team strived to ensure a quality service, improvements were required to ensure that the service is adequately resourced to ensure effective delivery of care and support in line with the statement of purpose. Improvements were required to staffing arrangements, to ensuring that the person in charge had adequate resources to fulfill the role. Further oversight was required in relation to restrictive practices, to the notification of required incidents to the Chief Inspector and to personal planning documentation.

There had been a number of recent changes to the management arrangements in the centre. The Chief Inspector had received a notification of a new person in charge on 7 November 2022. The person in charge advised that 12 hours per week had been allocated to the operational management of this centre. However, due to current staffing shortages, the person in charge was working 36 hours per week providing support as a social care worker and was trying to fulfil her management role out of hours. The person in charge is supported by the assistant director of client services who was appointed to the post in recent months. The inspector met with both the person in charge and the assistant director of client services. They advised that staff recruitment was on-going but outlined the current challenges in recruiting staff and advised that it was planned to appoint a team leader to further support the person in charge in their role. An updated statement of purpose had been recently submitted reflecting the changes to the management arrangements in the centre.

While there were arrangements in place for out of hours at weekends, there were still no formal on-call arrangements in place to ensure that staff were adequately supported out of hours during the weekdays. The assistant director of client services advised that following the successful recent recruitment of two senior managers, formal on-call management arrangements were due to be put in place shortly for all days of the week.

Staffing levels were not in line with those set out in the statement of purpose, there were now only four staff employed including the person in charge. On the day of inspection while there were adequate staff on duty to meet the needs of residents, staffing arrangements required review. There were two staff on duty in the morning time, two staff on duty in the evening time until 22.00 and one staff on sleepover duty at night time. The staff roster reviewed indicated that this was the regular pattern and that an additional staff member was allocated when the resident who required one to one support was staying in the centre. Staff spoken with advised of recent staffing shortages and how all staff including the person in charge were now working additional hours in order to cover the rota. They advised that this was not

sustainable in the long term. The minutes of staff meetings reviewed, the findings of a recent provider led audit and the risk register all identified that staffing shortages were a challenge for the service. This impacted upon the overall governance and oversight of the centre and potentially on the quality and safety of the service. Staff spoken with were also concerned that a resident who required one to one support who was currently staying one night a week could not be facilitated to stay additional nights due to the current staff shortage.

The management team had provided ongoing training for staff. Training records reviewed identified that all staff had completed mandatory training. Staff spoken with confirmed that they had completed mandatory training including fire safety, safeguarding and behaviour management. Additional training including, safe administration of medicines and various aspects of infection control had also been provided to staff.

The provider had systems in place to monitor and review the quality and safety of care in the centre. The assistant director of client services advised that the annual review on the quality and safety of the service was due for completion in January 2023. An unannounced provider led audit had recently been completed on 6 December 2022. The audit had identified a number of areas for improvement including governance and management and restrictive practice. The action plan clearly set out the improvements required along with the person responsible for ensuring compliance. The person in charge advised that the action plan was currently in progress, for example, a meeting had taken place with the family, psychologist and staff team to discuss the impact of some restrictive procedures on the rights of a resident. A further meeting was scheduled with the behaviour support therapist and psychologist for January 2023. However, other issues identified had not yet been followed up. Notifications as required by the regulations in relation to restrictive practices used had still not been submitted to the Chief Inspector.

Monthly medication management audits had been completed and the results of recently completed audits indicated satisfactory compliance. The person in charge showed the inspector templates for a monthly audit schedule which they planned to implement in 2023 in order to assist them in maintaining oversight of the quality and safety of care in the centre. Monthly audits were planned in areas such as fire safety management, medication management, infection, prevention and control, finances and residents files.

There was a comprehensive complaints policy in place which clearly outlined the duties and responsibilities of staff. The complaints procedure was displayed and available in an easy read format. However, it required updating to reflect the current nominated complaints officers. The inspector was advised that there had been no complaints received and there were no open complaints. There were systems in place for recording, investigating and review of complaints. Staff had recently discussed the complaints procedure and how to make a complaint with residents at weekly house meeting.

Regulation 14: Persons in charge

A new person in charge had been appointed in November 2022. She had the required qualifications and experience for the role. She worked full-time in the centre and was well known to residents and staff.

Judgment: Compliant

Regulation 15: Staffing

Staffing arrangements in the centre require review. Staffing levels were not in line with those set out in the statement of purpose, there were now only four staff employed including the person in charge. Staff spoken with advised of recent staffing shortages and how all staff including the person in charge were now working additional hours in order to cover the rota. They advised that this was not sustainable in the long term. The minutes of staff meetings reviewed, the findings of a recent provider led audit and the risk register all identified that staffing shortages were a challenge for the service. This impacted upon the overall governance and oversight of the centre and potentially on the quality and safety of the service. Staff spoken with were also concerned that a resident who required one to one support who was currently staying one night a week could not be facilitated to stay additional nights due to the current staff shortage.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff who worked in the centre had received mandatory training in areas such as fire safety, behaviour support, manual handling and safeguarding. Additional training was provided to staff to support them in their role including infection prevention and control, hand hygiene, putting on and taking off PPE (personal protective equipment) medicines management, epilepsy and administration of epilepsy medicines.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were required to ensure that the service is adequately resourced to ensure effective delivery of care and support in line with the statement of purpose. Staffing levels were not in line with those set out in the statement of purpose, there were now only four staff employed including the person in charge. Due to current staffing shortages, the person in charge was providing support as a social care worker and was trying to fulfil her management role out of hours. There were still no formal on-call arrangements in place to ensure that staff were adequately supported out of hours during the weekdays. Some issues identified in a recent provider led audit had not yet been followed up. Notifications as required by the regulations in relation to restrictive practices used had still not been submitted to the Chief Inspector. Further oversight was required in relation to restrictive practices to ensure compliance with national policy.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not provided the Chief Inspector at the end of each quarter of the calendar year with a written report in relation to the occasions on which restrictive procedures including physical, chemical or environmental restraints were used and occasions on which the fire alarm equipment was operated other than the purpose of fire practice, drill or test of equipment.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a comprehensive complaints policy in place which clearly outlined the duties and responsibilities of staff. The complaints procedure was displayed and available in an easy read format. However, it required updating to reflect the current nominated complaints officers.

Judgment: Substantially compliant

Quality and safety

The management team and staff strived to ensure that residents received an individualised, safe and good quality service, however, as discussed under the capacity and capability section of this report, improvements required in relation to

governance and management, staffing and restrictive practice had the potential to impact negatively on the quality and safety of the service provided. Some improvements were also required to personal planning documentation and risk assessments to ensure that they were up to date and reflective of the support needs of residents.

The inspector reviewed a sample of residents' files and noted some inconsistencies in the personal planning documentation. 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. However, there were no progress updates recorded and therefore, the inspector was unable to assess if personal goals had been achieved or were in progress.

Staff spoken with were familiar with and knowledgeable regarding residents up-to-date healthcare needs. There was a care plan in place for a resident with an specific healthcare need. Residents had access to general practitioners (GPs), out of hours GP service and a range of health and social care professional services. A review of a sample of residents files indicated that some residents had been reviewed by a range of healthcare professionals including psychologist, speech and language therapist (SALT), social care worker, behaviour therapist, dentist and chiropodist. Residents had also been supported to avail of vaccination programmes. Each resident had an up-to-date hospital passport which included important and useful information specific to each resident in the event of the required admission to hospital. Staff spoken with advised that some families managed and arranged all healthcare visits for other residents, however, there was nothing documented in these residents files to indicate the healthcare arrangements in place.

All staff had received specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm. There were comprehensive and detailed personal and intimate care plans to guide staff. The support of a designated safeguarding officer was also available if required. The inspector noted that residents who required support with behaviours of concern had plans in place outlining triggers as well as detailing proactive and reactive strategies to support them. Residents had access to regular mental health reviews. The person in charge advised that there were no safeguarding concerns at the time of inspection. All staff had completed training in the management of behaviours that challenged. Residents who required supports with communication had comprehensive plans in place which were tailored to their individual communication preferences and support needs. Some staff had received training on a specific communication method used by one of the residents.

Improvements and further oversight were required in relation to restrictive practice to ensure compliance with national policy and evidenced based practice. Staff spoken with confirmed that there were a number of restrictive practices in use on a regular basis, some were used occasionally while others recommended as part of a crisis intervention protocol had not been used to date. There was no evidence

available to show the impact upon residents rights, to show a clear rationale for their use or to show that other alternatives were tried or considered. While there was a template available to log the use and duration of each restraint, these logs had not been completed. The use of some restrictive procedures referred to the restrictive practice committee in August 2022 had not yet been approved as the committee had sought further specific details and updated guidance from the psychologist and behavioural therapist. The updates requested had not yet been submitted to the committee. The recent provider led audit had also identified a number of issues, reporting that there was a lack of clarity on restrictive practices, their use, recording and protocols. The person in charge and assistant director of client services advised that a further meeting with the behaviour therapist and psychologist was arranged the week following the inspection and they had planned to review all restrictive procedures and supporting documentation.

The staff team demonstrated good fire safety awareness and knowledge of the evacuation needs of residents. The fire equipment had been serviced in May 2022. The fire alarm was being serviced on a quarterly basis. Daily, weekly and monthly fire safety checks were being recorded. Fire exits were observed to be free of obstructions. Training records reviewed indicated that all staff had completed fire safety training. Regular fire drills had been completed simulating both day and night time scenarios. The times taken to evacuate residents provided assurances that residents could be evacuated safely and in a timely manner. All residents and staff had been involved and participated in fire drills. The importance of fire drills had been discussed with residents at recent house meetings.

There were generally good arrangements in place to manage risk in the centre. There was a risk register in place that had been recently reviewed. Individual risk assessments were in place for some residents, however, the inspector noted that a risk assessment for risk of absconding required updating to reflect all control measures in place as well as some further identified control measures that were planned to be put in place such as increasing the height of a fence, repair to front gate and planting of hedging.

Regulation 26: Risk management procedures

While there were systems in place for the identification, assessment, management and on-going review of risk. Improvements were required to ensure that an individual risk assessment in place for a resident at risk of absconding was up-to-date to reflect all control measures in place as well as some further identified control measures that were planned to be put in place such as increasing the height of a fence, repair to front gate and planting of hedging.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Staff demonstrated good fire safety awareness and knowledge of the evacuation needs of residents. Regular fire safety checks were completed. All staff had completed training in fire safety. Regular fire drills involving staff and residents were completed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Some improvements were required to the personal planning documentation. While personal plans had been developed in consultation with residents, family members and staff. There were no progress updates recorded and therefore, the inspector was unable to assess if personal goals had been achieved or not. Staff spoken with advised that some families managed and arranged all healthcare visits for some residents, however, there was nothing documented in these residents files to indicate the healthcare arrangements in place.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had regular and timely access to general practitioners (GPs) and health and social care professionals. A review of residents files showed that residents had been referred and recently assessed by a range of allied health professionals. Residents had availed of the COVID-19 vaccine programmes.

Judgment: Compliant

Regulation 7: Positive behavioural support

Improvements and further oversight were required in relation to restrictive practice to ensure compliance with national policy and evidenced based practice. Staff spoken with confirmed that there were a number of restrictive practices in use on a regular basis, some were used occasionally while others recommended as part of a crisis intervention protocol had not been used to date. There was no evidence available to show the impact upon residents rights, no risk assessment, no clear rationale for their use or evidence that other alternatives had been tried or

considered. While there was a template available to log the use and duration of each restraint, these logs had not been completed.

Judgment: Not compliant

Regulation 8: Protection

Safeguarding of residents was promoted through staff training, management review of incidents that occurred and the development of comprehensive intimate and personal care plans. There were no safeguarding concerns at the time of the inspection. The support of a designated safeguarding officer was also available if required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to live person-centred lives where their rights and choices were respected and promoted. The privacy and dignity of residents was well respected by staff. Staff were observed to interact with residents in a caring and respectful manner. Information was available to residents in a suitable accessible format. Residents continued to be consulted with and topics such as the human rights charter, staying safe guide and complaints procedure were discussed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Raceview Services OSV-0008242

Inspection ID: MON-0036733

Date of inspection: 04/01/2023

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
PIC has risk escalated staffing concerns and the impact of same with PPIM and Human Resources Dept.
Human Resources has advertised for social care worker and care assistant positions externally in January 2023.
Continuous communication is ongoing between PIC, PPIM and the Human Resources Department regarding recruitment developments.
Interviews took place on 16th the February 2023 and as a result of this, two suitable candidates have been identified to fill 2 of the current vacancies. Recruitment process continues for remaining positions and induction, training will be completed by end of March, pending successful completion of the recruitment process.
Until the team is fully recruited, the interim arrangements are for vacant lines on the roster to be filled by permanent staff, who currently have part-time contracts and have agreed to temporary additional hours. We also have access to agency staff who will support us if necessary.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
Recruitment is ongoing to ensure effective delivery of care and support in line with the statement of purpose. This will facilitate the PIC to complete administration responsibilities effectively when the team is fully recruited. In the interim, the PIC will be facilitated to access their protected administrative hours by other team members working additional hours.

There has been progress on recruitment actions with suitable candidates identified to fill 2 of the 4 vacancies on the staff team. The recruitment process continues for remaining positions and induction, training will be completed by end of March, pending successful completion of the recruitment process. Agency and relief staff are also available if additional support is required for shifts</td></tr>
</table>

A revised 7/7 on-call structure has been identified by the Senior Management Team, and arrangements for this are currently being finalised. It is intended that the new on-call arragnements will be communicated across services and implemented by end of March 2023. All issues included in provider led audit have been followed up on and a detailed action plan is in place to outline timelines and responsibilities. Restrictive practices have been reviewed within the centre and all relevant paperwork is now up to date to ensure compliance with national standards. All restrictive practives will be clearly outlined in notifications to the chief inspector going forward via quarterly returns.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All restrictive practives, occasions on which the fire alarm equipment was operated other than the purpose of fire practice, drill or test of equipment and other notifiables will be clearly outlined in notifications to the chief inspector going forward via quarterly returns by the Person in Charge.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The complaints procedure within the centre has now been updated to reflect current complaints officers and the easy to read format discussed with residents at the weekly house meeting.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Individual risk assessment reviewed and updated to identify current control measures in place for one resident at risk of absconding.	
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: Progress update forms now in place to be monitored regularly by keyworkers and overseen by PIC monthly. Healthcare arrangements now clearly documented in each resident's file.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Restrictive Practices within the Centre have been reviewed in conjunction with Multi-Disciplinary Team input. All documentation now reflects the impact on Residents, rationale for the use of same and all restrictions are logged effectively to ensure clear oversight.	

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	31/03/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/03/2023
Regulation 23(1)(c)	The registered provider shall ensure that	Not Compliant	Orange	31/03/2023

	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.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	10/01/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	01/02/2023
Regulation 31(3)(b)	The person in charge shall ensure that a written report is	Not Compliant	Orange	01/02/2023

	provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or test of equipment.			
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.	Substantially Compliant	Yellow	05/01/2023
Regulation 05(6)(c)	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	Substantially Compliant	Yellow	10/01/2023

	circumstances, which review shall assess the effectiveness of the plan.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	26/01/2023