Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centres for Disabilities (Adults)

Name of designated centre:	Alder Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Announced
Date of inspection:	12 & 13 February 2018
Centre ID:	OSV-0004060
Fieldwork ID:	MON-0020792

About the designated centre

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

Alder Services provides services to those with an intellectual disability who require support ranging from minimum to high levels of care needs. The service can accommodate both male and female residents from the age of 18 upwards. The service can accommodate up to five permanent residents at a time and operates seven days a week. Respite services are also available for another five residents on the basis of planned, recurrent, short-term placements of varying durations. During the day, service users attend a variety of day services and some service users are involved in supported employment. However, in the case of short-term illness, Alder Services will endeavour to make alternative arrangements particularly if a person is unwell and is not able to attend their day service.

The following information outlines some additional data of this centre.

Current registration end date:	27/07/2018
Number of residents on the date of inspection:	10

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information and information submitted by the provider or person in charge 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 to 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 summarize our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions:

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
12 February 2018	10:30hrs to 19:00hrs	Thelma O'Neill	Lead
13 February 2018	09:30hrs to 16:00hrs	Thelma O'Neill	Lead

Views of people who use the service

At the time of the inspection the centre was at full occupancy, the inspector met with seven of the ten residents accommodated in this centre. Residents expressed satisfaction to the inspector about the support and care they received at the centre.

The inspector observed that residents were comfortable with the support provided by staff on the day of inspection. Ten satisfaction questionnaires had been completed by the residents and their families which stated that in general, they were very happy with the support being provided in this centre. However, one resident was not happy about the time the transport services collected them to bring them to work in the mornings stating that this was too early.

In particular, the residents told the inspector that they were happy that they can now remain in their own home at the weekend to receive their respite service and that the change has minimised the disruption to them at weekends.

Capacity and capability

The inspector found the capacity and capability of the provider to deliver a safe quality service was impacted by the current operational management systems in this centre and required improvement.

While the inspector found their was adequate staff resources and a dedicated staff team working in this centre, there were areas of service delivery that were not ensuring a high quality and safe service and standard of care to residents.

The inspector found areas for improvement identified during the last inspection remained incomplete; in relation to, complaints management, assessments of residents health and social care needs, contracts for service provision, restrictive practices, safeguarding and health and safety concerns, medication practices and staff training.

The provider had submitted a complete application to renew the registration of this centre, as the current registration expires on the 27/7/2018. As part of the announced renewal of registration inspection, the inspector inspected against 20 regulations, six of the regulations were compliant, four substantially compliant and ten regulations were not compliant with the Regulations.

While the inspector received positive feedback from the residents and family members using this service, the inspector found that complaints by some residents or their advocates had not been effectively managed. In addition, safeguarding investigations were not completed and recommendations from the safeguarding team had not been implemented into practice.

Furthermore, the impact of some residents behaviours of concern on their peers' rights and quality of service had not been adequately assessed. Restrictive practices in the centre continued to be used without an appropriate assessment of need, or approval from the organisations restrictive practice committee. This was an action from the last inspection that had not been addressed.

The inspector reviewed quality assurance measures taken by the person in charge to audit service provision and found the audits were not effective and had failed to identify areas of concern or non-compliance's with the regulations; such as, complaints management, notifications, medication errors and the statement of purpose.

The inspector saw the annual review and the unannounced six-monthly audit completed by the provider, of their assessment of the quality of care and service provision in this centre. The inspector found that while these quality assurance reports had identified some areas where improvement was required, action had not been taken to address these issues. In addition, several incidents had occurred in the centre which required immediate action by the provider, and these quality assurance reports had not identified or addressed these issues, despite some of these incidents having reoccurred.

The inspector found that there was adequate staffing in this centre; however, a staff training analysis had not been completed as per previous action plan response, to identify staff training requirements to meet the assessed needs of the residents. For example, staff had no training in diabetes or epilepsy management and infection control and risk management.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted the required documentation for the renewal of the registration of this designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full time in this centre and had the educational and management qualifications required for the post.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that an appropriate number of staff employed to meet the assessed needs of residents. Furthermore, the provider's recruitment process ensured that all staff documentation required under Schedule two of the regulations was obtained.

Judgment: Compliant

Regulation 22: Insurance

The centre had appropriate insurance cover in place for the centre.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

All residents now have written agreement in place; however, their written agreements did not accurately reflect the current services they received since changes had occurred to these in May 2017.

These agreements also failed to clarify that the service only opened for 48 weeks per year and would close for four weeks per year, which would require residents and their families to make alternative arrangements for those weeks. The lack of clarity regarding service provision and costs was an action from the last inspection that was not complete.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not reflect both the services and facilities provided at the centre or contain all information required under Schedule 1 of the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all incidents occurring was maintained in the designated centre; however, not all of these incidents were reported to HIQA as required by the regulations.

These included incidents; such as, unexplained absences of residents from the centre, minor injuries not being submitted on the quarterly notifications, restrictive practices in use in the centre were not notified as required and some notifications were not submitted within the required time frame.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All schedule five policies and procedures were accessible to staff on the organisations website.

Judgment: Compliant

Regulation 16: Training and staff development

The provider failed to provide adequate opportunities for staff to attend training relevant to the care and support needs of the residents. For example, diabetes care or epilepsy and infection control management. Staff training was an action from the last inspection that was not adequately addressed.

Judgment: Not compliant

Regulation 23: Governance and management

Improvements were required in the governance and management of this centre, in relation to operational management, leadership, auditing of centre and the annual report. This was an action from the last inspection and was not addressed.

The quality assurance systems in place by the provider were not robust, risks and hazards were not escalated and audits completed had not identified the current risks in the centre.

Judgment: Not compliant

Regulation 34: Complaints procedure

The two complaints officers for the centre did not have any training in complaints management and were not involved in investigating complaints.

Complaints made in the centre were not always being identified as complaints and were therefore not investigated and managed appropriately.

The inspector was told that complaints were being investigated and closed; however, one complaint which had been repeated on several occasions, had not been addressed to the satisfaction of the complainant. This was an action from the last inspection not addressed.

Judgment: Not compliant

Quality and safety

The inspector reviewed the quality and safety of the service provided to the residents and found that fire safety management was compliant; however, improvements were required in all of the other regulations inspected. For example, personal plans and healthcare assessments, the investigation of safeguarding concerns, management of behaviours that challenge, risk management, general maintenance and the management of residents personal finances.

The inspector found that the assessments of residents health and social needs were not completed or updated as residents needs changed. Residents social goals were not clearly identified in their person-centred plans and while they were supported to participate in local community activities, it was not clear that these activities were

their individual choice, or solely the activity available to them in this service at the time.

Arrangements were in place to support residents on an individual basis to receive services to enjoy best possible health. Residents had access to a GP, and other allied health care professionals as required. However, the inspector found that the actions from the last inspection had not been completed, in relation to the need for a comprehensive healthcare assessment and care plans which included the resident's history, investigations, treatments, monitoring and supports required.

Staff continued to require specific training in some of the residents medical conditions. The inspector found that notes in the residents file did not guide staff as to how to support the residents when required, for example, residents with diabetes or epilepsy or food and nutritional needs.

There was a risk management policy in place to address the risks present to residents, visitors and staff.The policy advised that these risks were to be recorded on the organisational risks register; however, the risks in the centre were not recorded on the risk register, such as incidents of missing persons, residents left unsupervised, falls risks, medication errors, safeguarding concerns, risks of behaviours that challenge and infection control risks.

While residents individual risks were assessed on a risk assessment, the control measures documented within these risk assessments lacked sufficient detail in many instances and did not reflect the actual practices utilised in in the centre to manage these risks. For example, in the management of the risks associated with behaviours that challenge, residents leaving the house unsupervised, choking risks, safeguarding risks from peers.

There were policies and procedures in place for the management of medication in this centre. However, the management of medication errors was not robust. There had been 18 incidents of adverse events reported in this centre over a 12 month period. These errors were similar in nature and had not been identified as a concern on a recent medication audit, and as a result appropriate action had not been taken to minimise these issues and prevent further medication errors for the residents.

There were systems in place and supports available to staff to management behaviours of concern in the centre. Some residents had behaviour support plans in place; however, despite a plan in place, incidents of concern continued to occur and some of these behaviour’s were negatively impacting on the other residents in the house. The inspector found that the impact of these behaviours on other residents had not been assessed and managed.

Restrictive practices continued to be used in the centre; however, this practice was not agreed or managed in-line with organisation's policies and procedures. This was an action from the last inspection that was not addressed.

The inspector found that the identification and management of safeguarding concerns in the centre required review; in particular, there was no assessment of

the impact of behaviours that challenge on residents in the centre. There were some incidents of physical or psychological interactions between residents that were not identified as potential safeguarding concerns and residents did not have safeguarding plans in place.

In addition, the inspector found that the recommendations of a safeguarding investigation had not been implemented, despite being made over two months previously. The inspector also found that individuals involved in the investigation, including the complainant, had not being informed of the outcome of the investigation.

Residents were supported by staff to manage their personal finances. Staff assisted residents to purchase items and pay for their bills; however, residents accommodation fees were not paid in a timely manner, and in one case had accumulated up to €1,900 in overdue fees for over a years accommodation.

General maintenance requests in the centre were well managed; however, the inspector found that a maintenance request to repair a damaged ceiling was outstanding since July 2017 and a plumbing issue in a shower had not been addressed, resulting a resident not being able to use their en suite shower.

Regulation 27: Protection against infection

Residents' medical conditions or behaviours that challenge increased the risk of Healthcare associate infections (HCAIs), but these risks had not been appropriately risk assessed or documented in the residents healthcare notes.

Staff had not received infection control training necessary to prevent HCAIs by ensuring that all staff were aware of the requirements to effectively manage clinical/hazardous waste, linen and laundry, equipment, medical devices and environmental cleaning.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had effective fire safety arrangements in place in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The actions from the last inspection had not been implemented as stated.

The inspector found that although residents assessments of needs had been completed since the last inspection, they did not identify residents health and social care conditions or goals, and did not specify a plan to manage residents care.

The inspector found that respite residents had not had a compatibility assessment prior to respite admissions. These assessments were required to ensure that residents receiving a respite service together would be safe and that they would receive appropriate care and support while on respite.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider failed to assess or monitor the impact or the safety concerns when some residents displayed behaviours that challenge in the centre.

Restrictive practices were in place for two residents; however, the restrictive practices had not been fully assessed to ensure they were in line with positive behaviour supports and organisational policies and procedures. This was identified as an action on the last inspection and the had not been completed.

Judgment: Not compliant

Regulation 12: Personal possessions

The residents were not supported to fully manage their finances; for example, Two residents accommodation fees were not paid in a timely manner and residents fees accumulated for over a year, resulting in a significant bills for the residents to pay that they were not aware they owed.

Judgment: Substantially compliant

Regulation 17: Premises

In one of the houses, one ceiling had been identified as requiring painting since July 2017, but this had not been completed.

One resident showed the inspector their bedroom and told the inspector that the en suite shower had not been working for a long time. This resident had to use the main bathroom to shower instead of being able to shower in their own private en-suite.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were at least 18 medication errors recorded in the centre, mostly due to incorrect medications being sent into the centre from home. The management of this issue had not been addressed to prevent a serious incident occurring.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

1. Hazards or incidents that had occurred in the centre, had not been risk assessed or appropriately managed.

2. There were serious risks that were not identified or risk assessed or placed on the organisational risk register in the centre. For example, missing persons risks, medication errors, residents being left alone unsupervised, behaviours that challenge, falls risks, lack of individualised health and social care assessments, and choking risks.

3. There was no effective system for investigating and learning from all incidents and accidents.

4. Staff did not have training in risk management or infection control management.

Judgment: Not compliant

Regulation 8: Protection

Respite residents did not have compatibility assessments completed prior to respite admissions or following peer to peer altercations in the centre. No safeguarding

plans had been put in place to ensure residents were protected and these incidents would not re-occur. In one open safeguarding concern, the inspector found the investigation was not complete as the recommendations from the safeguarding team had not being implemented
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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 22: Insurance	Compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Alder Services OSV-0004060

Inspection ID: MON-0020792

Date of inspection: 13/02/2018

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 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • All residential residents have received a new Contract of Care detailing their service provision. • All respite service user's contracts of care have been reviewed and updated detailing their specific respite location. • Addendums have been included with all Contracts of Care detailing all additional costs to the service-users, that is not included as part of the Contract of Care, e.g., taxis, toiletries etc. • As part of the Referrals and Admissions process, Contracts of Care are issued to new admissions. This process will be closely monitored in future.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • A full review has been undertaken of the Statement of Purpose to ensure the contents are in line with Schedule 1 of S.I. 367 regulations. Statement of Purpose has been amended to reflect these requirements. • The Statement of Purpose will continue to be reviewed as part of Support and Development meetings between the Person in Charge (PIC) and Person Participating in Management (PPIM), particularly in terms of ensuring the service is operating in line with the Statement of Purpose. • The Statement of Purpose will be reviewed as part of the services' Annual Review.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents:	

- Notifications' and statutory obligations are now a standing item on the Person in Charge (PIC) and Person Participating in Management (PPIM) bi-monthly support meetings, which will also include auditing against timeframes.
- This is also a standing agenda item on the service's monthly team meetings.
- Information detailing HIQA's Notifications have been circulated to all staff, with the instruction to re-read and sign off on same. This will be reinforced through a briefing session that will be held with the staff team on 10/04/2018, to ensure all staff are fully aware and knowledgeable about notification requirements and their obligations.
- Notifications as per requirement have now been submitted

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

- Person in Charge has undertaken a full review of the Designated Centre's Training Needs Analysis (TNA).
- Complaints, Restrictive Practices and Infection Control Training has been completed since the inspection.
- Date for Diabetes Training is 17/04/2018. Updated information on Diabetes has been shared with the staff team and placed on relevant file.
- Risk Management Policy and Procedure has been circulated to all staff members, with the instruction to re-read and sign off on same. This will be further re-iterated at the team meeting on 10/04/2018 through a briefing session by the Quality and Compliance Manager.
- PIC and PPIM attended a briefing session on Risk Management at a Frontline Manager's Day on 13/03/2018.
  Briefing session on Positive Behaviour Support is scheduled with the staff team on 10/04/2018; in the interim, staff have been requested to re-read the Positive Behaviour Support Policy, Procedures and Guidelines
- The Management of Epilepsy training was completed by all staff.
- Staff Training and ongoing professional development will continue to be a standing item on Staff Development and Support meetings.
- Specialist staff will be utilized for training. Training materials and handouts will be available as a resource and all training provided will be evaluated. The use of an eLearning tool where relevant will be used to reinforce knowledge acquired. Staff meetings will cover various elements of training including dissemination of knowledge, and cross fertilization across staff group/skill mix will be encouraged.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- Bi-monthly Support and Development meetings have been scheduled between PIC and PPIM.
- PIC has devised a schedule of support meetings for all frontline staff.
- An Unannounced Provider led Audit was completed by the Quality and Compliance Manager on 23/02/2018 and the Registered Provider Representative has advised that further Unannounced Provider Led Audits will take place each month for the

next six months.

- A self-audit process has been established by the PIC, with tools for auditing Complaints, Finances, Service user Goals, Incidents and Medication has been set up. This will form part of the agenda for the Bi-monthly Support and Development meetings scheduled between the PIC and PPIM.
- A peer support person for further oversight of auditing has been put in place which commenced on 19/03/2018. This will be carried out monthly.
- A review of risks in the designated service has taken place, following which the Risk Register was updated with the Health and Safety Manager on 27/02/2018 with updates and additional information inputted, as required. This included a review of the location of the 'high' risks, which are now more easily accessible within the register.
- A new process has been developed to record the consultation and feedback from PPIM and Registered Provider Representative in relation to Designated Centres Annual Reviews.
- The Registered Provider has processes in place to oversee the quality of service, including a Quality Management System with Senior Management Team, Management Reviews, Quality and Safety Board Committee and Quality and Safety Executive Committee, Middle Management Team, Corporate Team. Additional unannounced visits and inspections will take place. The risk identified with regard to governance and management of this service has been escalated through this system, added to the Provider's corporate risk register and measures noted to deliver improvements, with continuous review.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- Complaints Training has been completed with the PIC and staff team on 08/03/2018. The nominated person for dealing with the complaints in the service is now the PIC and service user information detailing same is prominently displayed in the centre and service users are aware of same through house meetings.
- Complaints audit tool has been developed by PIC and forms part of monthly reviews by PIC.
- All complaints are currently being reviewed and closed off, as appropriate. There is currently one outstanding complaint, which is going through the complaints procedure at present.
- All complainants have been notified in writing of the outcome of their complaint, and in person, where necessary.
- Complaints management is overseen by the PPIM, as per Complaints Policy and Procedure.
- Complaints will be a standing item on the agenda for the bi-monthly PIC and PPIM meetings and staff meetings.
- Annual review will cover critical review of complaints in the centre.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection

against infection:

- All staff have now completed Infection Control training, and this risk has been updated in the Centre Risk register and individual risk assessments.
- Protocol is now in place for the management of self-induced vomiting by a service-user. This is included in the risk assessment for the service user.
- Policy on Infection Control and HSE Guidance Document is available in both locations.

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:

- A new process has been implemented in the service whereby PIC will convene an annual respite review meeting for all respite service users, which will include a review of the Assessment of Needs, specific healthcare and related issues, and medication.
- Letters have been sent to all respite service user families along with offers of respite requesting that up to date information on the service user's medication and healthcare needs are sent in with them, prior to them availing of the respite break. If it is noted that there is a pattern of non-compliance from families in relation to this request, this will be reviewed and all offers of respite will be subject to compliance with Ability West's policies and procedures in line with the Statement of Purpose. Social Workers will also be involved in this process in order to ensure best care for the service-users.
- PIC has organised a schedule for Circle of support meetings for all residents and respite service-users.
- A process of the identification of goals that can be worked on while a person is in on respite and recording of progress in this regard has been established. This monitors progress and completion of specific individual goals, and sign off by staff when completed.
- All issues of compatibility of respite service-users will continue to be addressed through the Respite and Community Services Manager and raised at the Short Breaks Prioritisation Committee's monthly reviews. This forum includes discussion about compatibility and appropriateness of respite service for individual's needs and support requirements.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- Application was made to the Restrictive Practices Committee to review the restrictive practice, and approval was received.
- Restrictive Practice log in place in the centre.
- Service user who displayed behaviours of concern that impacted other service-users no longer receives respite in this service and this individual is now availing of respite in a respite centre more suitable to their individual needs and supports, as per the Assessment of Needs.
- Briefing session will be held with staff team on 10/04/2018 on Positive Behaviour

Support
- Continuous monitoring of any potential impact of behaviours on others will be done, and addressed appropriately as per procedures.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
- Standing orders have been set up for two residents to ensure their fees are paid in a timely manner.
- Key-workers and PIC will review and sign off monthly on residents' finance accounts.
- Peer audit will include finance audit also.
- Finance Audits is included as part of PIC self-audit process

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- Painting as identified has been completed
- Replacement shower in en-suite has been completed.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
- Monthly medication and incident audits will be completed by the PIC. Schedule in place for completion of monthly medication and incident audits.
- Peer medication audits will be completed as per procedure.
- Letters have been sent to respite service user's families with offers of respite requesting up to date information on the service user's medication and healthcare needs, prior to them availing of the respite break. If it is noted that there is a pattern of non-compliance from families in relation to this request, this will be reviewed and all offers of respite will be subject to compliance with Ability West's policies and procedures in line with the Statement of Purpose. Social Workers will also be involved in this process in order to ensure best care for the service users.
- These letters will be sent to families prior to every respite break.
- Management of medication has been entered on the centre's risk register with measures noted, and continual review.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
- Risks were reviewed in the centre and the Risk Register was updated by the PIC and the Health and Safety Manager on 27/02/2018, with additional information inputted as required. This included a review of the location of the 'high' risks, which are now more easily accessible within the Risk Register document.
- 'High' risks will be reviewed by the PIC on a monthly basis and as required.
- Management of risk will be included as a standing item on the PIC and PPIM's bi-monthly meetings.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- Service user who displayed behaviours of concern that impacted other service users no longer receives respite in this service and this individual is now availing of respite in a more suitable centre to their individual needs and support requirements.
- All issues of compatibility of respite service users will continue to be addressed through the Respite and Community Services Manager and raised at the Short Breaks Prioritisation Committee's monthly reviews. This forum includes discussion about compatibility and appropriateness of respite service for individual's needs and support requirements.
- All staff have been instructed to re-read and sign off on the Safeguarding Vulnerable Adults Procedure.
- Refresher Safeguarding Training for the staff team will be completed by Designated Officer on 17/04/2018
- 'The Right to Feel Safe' document is regularly discussed at resident's house meetings.
- Multi-disciplinary Meeting held on 23/03/2018 to review actions and close off open safeguarding issue as appropriate.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Yellow	21/03/2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	17/04/2018
Regulation 17(4)	The registered provider shall ensure that such equipment and	Not Compliant	Orange	27/03/2018

	facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	23/03/2018
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and	Not Compliant	Orange	23/03/2018

	safety of the services that they are delivering.			
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Yellow	21/03/2018
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Yellow	21/03/2018
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Substantially Compliant	Yellow	21/03/2018
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	Not Compliant	Orange	16/03/2018

	risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	16/03/2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	23/03/2018
Regulation 03(2)	The registered provider shall review and, where	Substantially Compliant	Yellow	16/03/2018

	necessary, revise the statement of purpose at intervals of not less than one year.			
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Yellow	20/03/2018
Regulation 31(1)(e)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any unexplained absence of a resident from the designated centre.	Not Compliant	Orange	21/02/2018
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	Not Compliant	Orange	14/02/2018

	a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 31(3)(d)	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 injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	14/02/2018
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	08/03/2018
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	16/03/2018
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint,	Not Compliant	Orange	16/03/2018

	outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
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 basis.	Not Compliant	Orange	21/02/2018
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	21/02/2018
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 circumstances,	Not Compliant	Orange	23/03/2018

	which review shall assess the effectiveness of the plan.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Yellow	10/04/2018
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	28/02/2018
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	23/03/2018
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	23/03/2018