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

Name of designated centre:	Boulia Accommodation Service
Name of provider:	RehabCare
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	05 December 2018
Centre ID:	OSV-0005748
Fieldwork ID:	MON-0025712

About the designated centre

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

This designated centre was established in July 2018; the centre was established to provide a community based home for four male residents transitioning from a larger congregated setting and some of whom had a long history of living in a congregated setting.

The provider aims to provide each resident with a safe, homely environment, encourage independence but also to provide each resident with any support that is required. The provider aims to match the service delivered as closely as possible to resident's individual requirements through the process of assessment and personal planning. The service operates and is staffed on a full-time basis; the model of support is based on the social model of care.

The centre is located in a rural location but transport is available to residents; there is a well serviced local village with for example a pharmacy, post office and a shop. A larger busy town is approximately a twenty minute drive away and staff support residents to visit both the village and the town on a regular basis.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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, 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
05 December 2018	09:30hrs to 19:30hrs	Mary Moore	Lead

Views of people who use the service

The ability to engage with residents was limited by the requirement to respect a resident's request for space and privacy so as to prevent distress and behaviour of risk to residents and staff. At the outset of the inspection one resident clearly communicated to the inspector that they did not wish to engage with the inspector or for the inspector to enter what the resident viewed as their personal space, that is the main kitchen, main living room, main bathroom and their own personal bedroom; once this was respected there was no further issue with the inspector being in the house. These requests were not peculiar to the inspector and in reality influence the day to day operation of the centre and the routines of all who live and work there.

As the day progressed there were opportunities to observe the routines of the house and engage with the remaining three residents. The inspector also reviewed records such as complaints and consultation between staff and residents to ascertain how residents felt and what they were saying about their life in the house. One resident presented as very content and at ease in the house and with the staff on duty and told the inspector that he was fine. One resident said that he did not like living in the house and wanted to move but did not specify why. The remaining resident said that he liked the house, he liked the staff and that the other residents were his friends but there were times when he was afraid and went to his room as a fellow resident got very cross. Residents also spoke about what was positive about life in the centre such as how they liked their bedrooms, the fact that they could lock and secure their room and their enjoyment of the trip to Dublin zoo the day before the inspection to see the current light display there.

When one resident left the house another resident produced musical instruments and a lively music session began; the atmosphere was relaxed and lively.

In summary, the inspector found that while there were many positive aspects to the service, the overall dynamic and routines of the house were dependent on the requirement of staff and residents to work around the needs and wishes of residents who were not compatibly living together.

Capacity and capability

The management structure was clear. Staff participating in the management of the centre were clear on their roles and responsibilities in ensuring that residents received a safe, quality service that was appropriate to their needs. There were systems for monitoring quality and safety, systems that identified failings and their impact. However, while many of the elements that represent good governance were evident, governance had not ensured that residents were in receipt of a safe, quality service that was appropriate to their individual and collective needs. The fundamental issue was the known unhappiness of one resident in this house and the

impact of this on the other residents; there was no solution to this placement issue at the time of this inspection.

The local management team consisted of the team leader, the person in charge and the integrated services manager. It was clear from speaking with them and from records seen that they had the capacity and ability to fulfil their roles, understood what a safe quality service, advocated on behalf of residents for this and strove to deliver it.

For example the inspector found that staffing levels and arrangements were reviewed and altered in response to the challenges within the service. These changes included the provision of two waking staff at night time and additional staff support by day to facilitate one to one support and greater community access for residents so that they could spend more time out of the house.

Staff were supported in their role and the challenges that presented in the centre by the provision of appropriate training, regular staff meetings and supervision meetings with the team leader and the person in charge.

Complaints were welcomed and seen as an opportunity to review and learn if necessary; there was evidence of good complaint management in line with the provider's policy. The person in charge maintained detailed records of all complaints received, the actions taken in response and whether the complainant was satisfied or not with the actions taken. Residents were actively supported by staff and internal and external advocacy services to progress matters that they were unhappy with. However, several complaints made by two residents were still largely unresolved by the actions taken to date by the provider in response. Residents concerns related to their safety and quality of life and are discussed and addressed in the next section of this report.

The person in charge monitored each reported accident and incident; trending and analysis of incidents was completed and there was evidence of actions taken to promote resident and staff safety and well-being, for example in response to falls. Based on the records seen in the designated centre the inspector was satisfied that there were robust arrangements for ensuring that incidents were reviewed and managed and that required notification was returned to HIQA (Health Information and Quality Authority).

The provider had made arrangements for the completion of an unannounced review of the service as required by the regulations; these reviews are required at least every six months; the provider completed this review three months following the opening of the service. The report was in draft format but was requested and made available to the inspector. The review was transparent and acknowledged the failings within the service; the reviewers sought feedback from residents; again this feedback reflected resident concerns about their life in the centre. However, while the review acknowledged and reported matters that were current and impacting on resident safety, no corrective plan of action issued in this regard.

In summary despite the many indicators of good governance as described above, that is a competent management team, consistent monitoring and evidence of

actions taken by the provider to bring about improvement, the provider had failed to satisfactorily resolve the placement issue that was at the core of the failings in this service. This failure resulted in a service that was not appropriate to residents need and a service that was not safe or of the best quality at all times. The impact on residents is discussed in the next section of this report.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge said that she had the support needed to exercise her roles effectively from the staff team, the team leader and senior management who were available as needed. The inspector saw that the person in charge did appropriately escalate matters that were beyond her scope to address. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs, of the general operation and administration of the designated centre and regulatory requirements.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements were appropriate to the assessed needs and number of residents. There was evidence that the provider reviewed and made alterations to both staffing numbers and arrangements in response to resident's individual and collective needs. Given that additional staff supports had been provided there was a requirement for relief staff; the inspector was satisfied that consideration was given to consistency so that residents received continuity of care and support and further staff recruitment was in process.

Judgment: Compliant

Regulation 16: Training and staff development

Existing and recently recruited staff were provided with mandatory and other training such as fire safety, safeguarding, medicines management and responding to behaviours of concern and risk. Training records were maintained and the person in charge and team leader were clear on each staff, their completed training and training in progress for recently recruited staff.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to satisfactorily resolve the placement issue that was at the core of the failings in this service. This failure resulted in a service where the governance had failed to ensure that the service was appropriate to residents' need and a service that was safe and of the best quality at all times.

The provider review of the quality and safety of the service acknowledged and reported matters that were current and impacting on resident safety, however, no corrective plan of action issued in this regard.

Judgment: Not compliant

Regulation 31: Notification of incidents

There were robust arrangements for ensuring that incidents that required notification to HIQA (Health Information and Quality Authority) were appropriately submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had policy and procedures on the receipt, recording, investigation, learning from and review of complaints. It was evident from the complaint records that residents and representatives had no hesitation in approaching either staff or management when they had a complaint. A complete record of complaints and their management was maintained. There were unresolved complaints; the provider acknowledged that they were not yet satisfactorily resolved.

Residents concerns related to their safety and quality of life and are discussed and addressed in the next section of this report.

Judgment: Compliant

Quality and safety

As discussed in the first section of this report there were many indicators of good

governance. However, residents were not happy living in this centre; this unhappiness was verbally articulated but was also frequently communicated in explicit behaviours that caused distress, created risk of harm, resulted in abuse amongst peers and risk of injury to staff. This resulted in a service that was not at all times safe and did not support an acceptable quality of life for residents.

The inspector found sound knowledge of residents, their needs, their required support and their expressed wishes and preferences. This knowledge was based on assessment, consulting with and listening to residents and their representatives. On a day to day basis staff sought to provide each resident with the care and support that they required; this care and support was set out in an individualised and comprehensive manner in the personal support plan. This plan was seen to be reviewed regularly by staff in consultation with the resident and relevant members of the multi-disciplinary team. The plan included residents personal goals and objectives and the plan for progressing these; there was a social and developmental theme to these goals such as learning new skills and supporting residents to seek and enjoy new experiences such as voluntary employment.

However, it was fully acknowledged, had been identified very early in the relocation process and was transparently documented that living in this centre was not suited to all residents needs and expressed wishes; the provider did not have the capacity within this service to provide what was wanted and required. The person in charge discussed the difficulties and challenges associated with the transition to this centre.

Because the service was not suited to meeting all resident needs, this resulted in resident unhappiness and dissatisfaction. This unmet need and resultant unhappiness manifested on a regular and consistent basis in behaviour that resulted in abuse and harm of peers and amongst peers. This pattern of peer to peer incidents emerged very shortly after admission to the centre and despite measures taken by the provider had not resolved or declined. Incident trending reports seen by the inspector indicated that there were days with no recorded incidents but days when up to 18 incidents had occurred the majority of which were directed at peers, two peers in particular. On the morning of this inspection and prior to the arrival of the inspector staff confirmed that such an incident had occurred.

There was an active safeguarding plan; this and discussion with staff highlighted the measures taken by the provider in response in an attempt to safeguard residents. These actions included clinical referral, revised staffing and staffing arrangements, education for residents on safeguarding and respecting others, trending and analysis of incidents to identify possible triggers and solutions, environmental modifications, support and input from the behaviour therapist and regular meetings with the funding body and the local safeguarding team.

However, very clearly these actions had not resolved safeguarding matters. The risk of harm was increased for all residents by the unpredictable nature of the incidents and by virtue of factors that increased their vulnerability such as their advanced age, mobility deficits and increased risk for falls.

The inspector saw that there were current guidelines for staff for preventing and

responding to behaviour; the person in charge said that she monitored practice and was satisfied that staff adhered to the guidelines at all times; staff had been consulted with and had input into the guidelines. On reviewing the positive behaviour support guidelines the inspector saw that there were behaviours that would require support and understanding in any care context. However, the behaviours of concern were in response to the unsuitably of the centre to the residents needs and expressed wishes and were not and could not be alleviated by the current model of shared communal living. Triggers for behaviour included living with other people, sharing common space like the kitchen with other peers.

On a day to day basis it was clear that staff respected each resident's individuality, their choices and preferences. Residents had meaningful access to and continued support from advocates; this was evidenced on inspection. However, it was not satisfactorily demonstrated that residents known will and preference influenced and guided decisions about where they lived, who they lived with and the care and support that they received. Three residents had clearly articulated their views, their level of unhappiness in the house and what they wanted in life. This was evident from speaking with residents and staff and from records seen such as complaints, consultation with residents, advocacy meetings and safeguarding meetings. Residents said that they were not happy living in the house and with each other, that they wanted the shouting and throwing of items to stop, that they were hurt and were afraid of being hurt. Residents said that they simply did not want to live with others and wanted to live in their own home; what was described in one record seen as a desire to have an ordinary life.

Though residents had transitioned to this service in early August 2018, resident monies had yet to transfer with them from the discharging facility. Staff advised that they did seek and did receive monies for residents as needed. There was evidence in the form of banking correspondence that the provider was taking action to address this but residents still did not have access and control over their own monies.

While there was scope for improvement overall the inspector found the provider had good arrangements for maintaining resident health and well-being. Residents' healthcare related needs were identified and residents had the access that they needed for example to their General Practitioner (GP), psychiatry, general and psychiatric nursing support, physiotherapy, behaviour support, chiropody and dental care. Staff were knowledgeable and responsive to residents changing needs and there was evidence of good collaborative working between staff, the GP, the pharmacist and for example neurology to ensure that residents enjoyed the best possible health. For example in response to an increased incidence of falls the inspector saw good collaborative working, timely referral, review of medicines, environmental modifications, physiotherapy review including a home visit, the provision of personal alarms and mobility aids. However, residents did occasionally refuse medical intervention; that is hospital review post a fall. In that context given the pattern of falls and injuries sustained, staff required education and guidance on monitoring and supporting residents with a possible head injury.

Overall the provider had systems for ensuring that residents were protected by safe

medicines management systems. Medicines were supplied by a local community based pharmacist who visited the centre weekly, who had attended a recent staff meeting and who was known to residents. Safe medicines management systems such as their prescription, reconciliation of instructions, review and update were described to the inspector. Prescribed medicines and their impact were considered and reviewed in line with residents presenting symptoms. Staff had completed safe medicines management training including the administration of medicines to be administered in emergency situations. There were regular occasions where residents refused prescribed medicines but there was a process for managing this and promoting medicines compliance. However, there was a pattern of medicines management errors including an administration recording error noted on inspection. The person in charge had an action plan for monitoring and responding to these incidents; the plan included phased responsive actions dependent on the type and number of incidents.

In practice the inspector found a good understanding of risk and risk impact and there was evidence of measures taken to reduce and management risk, for example in relation to falls prevention as discussed earlier. In practice, there was no underestimation of the risk posed to residents and staff in the centre including the safeguarding risk. However, explicit risk assessments seen including those that related to the safeguarding failings in the centre required review and updating; some were last reviewed in August 2018. Also inconsistency was noted in the residual risk rating of inter-related risks, such as safeguarding, the risk of aggression and violence at work and the psychological impact of behaviours. Given the unpredictability, the actual frequency, intensity and impact of incidents the inspector was of the view that the actual risk was not accurately calculated and was at times underestimated.

The provider had fire safety measures that protected residents and staff. The premises was equipped with a fire detection system, emergency lighting and fire fighting equipment. There was documentary evidence that these systems were inspected and tested at the required intervals. Escape routes were protected from smoke and fire by fire-resistant door-sets. Staff had completed fire safety training and undertook simulated evacuation drills with residents; residents co-operated fully with these and good evacuation times were achieved.

Regulation 12: Personal possessions

Residents did not have access and control over their own monies.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Explicit risk assessments required review and updating; some were last reviewed in

August 2018. Inconsistency was noted in the residual risk rating of inter-related risks. Given the unpredictability, the actual frequency, intensity and impact of incidents the inspector was of the view that the actual level of risk posed was not accurately calculated and was at times underestimated.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider ensured that there were effective fire safety management systems in place including arrangements for the safe evacuation of residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Procedures for the safe administration of medication were not at all times adhered to.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The centre was not suited to all residents needs and expressed wishes; the provider did not have the capacity within this service to provide what was wanted and required.

Judgment: Not compliant

Regulation 6: Health care

Given the pattern of injuries sustained by residents, staff required education and guidance on monitoring and supporting residents with a possible head injury.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Behaviours of concern were largely in response to the model of shared communal living and the unsuitably of this to the residents needs and expressed wishes and were not and could not be alleviated by behaviour management guidelines.

Judgment: Substantially compliant

Regulation 8: Protection

Unmet need and resultant unhappiness manifested on a regular and consistent basis in behaviour that resulted in abuse and harm of peers and amongst peers. The risk of harm was unsustainable and increased for all residents by the unpredictable nature of the incidents and by virtue of factors that increased their vulnerability such as their advanced age, mobility deficits and increased risk for falls.

Judgment: Not compliant

Regulation 9: Residents' rights

It was not satisfactorily demonstrated that residents known and consistently expressed will and preference influenced and guided decisions about where they lived, who they lived with and the care and support that they received.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Boulia Accommodation Service OSV-0005748

Inspection ID: MON-0025712

Date of inspection: 05/12/2018

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></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:
Background
There is an operational line management structure in place to oversee the management of the service, this structure supports service delivery from local level to national level across the organization. The organization is committed to ongoing oversight completing unannounced visits every six months and conducting an annual review of the service. The Quality and Governance Directorate with subject matter experts are actively supporting the service on an ongoing basis in terms of risk management, medication, safeguarding, regulations etc.

Actions
• Alternative placement has been identified within RehabCare Services. The resident will be supported to transition by 28th February 2019. This placement will meet the identified individual needs of the resident such as own bedroom/ bathroom/ sitting room/ dining room and 1:1 staffing.
• A detailed transition plan will be developed to support the transition by 11/01/2019.</td></tr>
<tr><td>Regulation 12: Personal possessions</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Background
The organisation's policy on Service User's Finances guides staff practice in terms of supporting residents with their finances and ensuring their personal possessions are kept safely.

Actions
• A person in care current and deposit accounts have been opened for each resident. The accounts are in the residents own names and will have a 2 authorised signatories in place. This was completed in November 2018.
• Following transfer of each residents Disability Allowance into these accounts the</td></tr>
</table>

provider will write to the HSE to transfer all their monies into their own bank accounts. This will be completed by 31st May 2019.
• Each residents HSE central account will be closed. This will be completed by 31st May 2019.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Background
RehabCare operate a robust risk management system. Processes are in place for the identification, assessment and review of risk to ensure adequate control measures are in place to manage all risks. Risk management practices aim to protect the safety and respect the rights of service users.

Actions
• Full review of all residents' risks assessments to be completed to ensure the actual level of risk posed is accurately calculated and estimated. Significant risks will be placed on the risk register. This will be completed by 04/01/2019.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Background
• The organisation's Medication Management Policy governs the management and administration of medication within services. The policy has been developed and is regularly reviewed to ensure it is in line with international best practice. Within the policy there is guidance on the completion of regular medication audits at service level.
• All incidents and near misses are reported and monitored on the organisation's incident management system. The PIC monitors incidents and ensures corrective actions are taken. These incidents are reviewed at team meetings in order to share learning amongst the staff team.
• Within the Quality and Governance Directorate responsibility for developing the organisation's medication policies and procedures in line with best practice is led by the Quality and Practice Officer, who holds a nursing qualification. The Quality and Practice Officer is available to support the service to ensure the policy is implement effectively at local level.
Actions
• Medication Error Action plan is in place
• Individual medication management Plan in place to be reviewed 02/01/2019 with update on protocols for staff to follow in the event of medication refusal by residents.
• Local Medication Procedure in place
• Advice Sought from the Community Mental Health Team in relation to consecutive decline of medicines and an Individual Risk assessment to be reviewed by 04/01/2019.

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:
Background
There is an annual screening of Resident needs, this informs the support plan which identifies their support needs and guides staff practice. The Resident is also supported to have ongoing action plans which enable them to pursue their goals. Based on the ethos of person centred planning Support Plans and Action Plans are developed in consultation with the resident. Plans are reviewed on an ongoing basis to review their effectiveness and there is formal review at minimum on an annual basis. The review looks at the effectiveness of the plan over the previous 12 months and encourages the resident to identify goals for the coming year.

Action
• Alternative placement has been identified within RehabCare Services. The resident will be supported to transition by 28th February 2019. This placement will meet the identified individual needs of the resident such as own bedroom/ bathroom/ sitting room/ dining room and 1:1 staffing.
• A detailed transition plan will be developed to support the transition by 11/01/2019

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Background
On an ongoing basis RehabCare supports residents to access support from healthcare professionals in the local community as and when required. On an annual basis there is a screening of resident's healthcare needs to ensure that all needs are identified and appropriate support sourced and provided. Guidance for staff practice to support residents with healthcare conditions is documented in individual plans.

Action
• Following consultation with the GP post seizure head injury observation guidelines for one resident will be devised and implemented by 15th January 2019. The Quality & Practice Officer (registered nurse) in the Quality & Governance Directorate will provide support to the PIC in this regard.
• Further training in relation to head injury observations to be provided to all support staff to be complete by 31st March 2019.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Backgound
• The organisation's Positive Behaviour Support and Restrictive Practices Policies guides staff practice when supporting Residents in this regard. Organisational policy requires that all staff must complete a 2-day MAPA Foundation course and an annual refresher thereafter throughout their employment with RehabCare. This training equips staff with the skills required to support Residents who experience behaviours that challenge.
• Behaviour management plans are in place where necessary and staff are knowledgeable and competent in the implementation of these plans. These plans are periodically reviewed and monitored to ensure they are meeting the needs of the

Resident.
• All restrictive practices must be approved by a Restrictive Practice Committee and are monitored and reviewed to ensure they are in place for the shortest duration possible.

Actions
• Alternative placement has been identified within RehabCare Services. The resident will be supported to transition by 28th February 2019. This placement will meet the identified individual needs of the resident such as own bedroom/ bathroom/ sitting room/ dining room and 1:1 staffing. This transition will address behaviours of concern that can be attributed to the model of shared communal living and the unsuitably of this to one residents needs and expressed wishes and could not be alleviated by behaviour management guidelines.
• A detailed transition plan will be developed to support the transition by 11/01/2019

Regulation 8: Protection	Not Compliant

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

• The organisation's policy on Safeguarding Vulnerable Adults which is in line with national HSE policy governs staff practice in this area. The organization has a zero tolerance policy to all forms of abuse and when issues arise the organization is committed to taking corrective actions to ensure all residents and staff are protected from all forms of abuse. The governance of the policy is overseen by Quality & Governance Social Worker / Safeguarding Lead supported a number of regional designated officers.
• All staff attend Safeguarding Training at time of recruitment and three year thereafter. This ensures that staff skills are in line with current best practice.

Action
• Alternative placement has been identified within RehabCare Services. The resident will be supported to transition by 28th February 2019. This placement will meet the identified individual needs of the resident such as own bedroom/ bathroom/ sitting room/ dining room and 1:1 staffing. This transition will result in the elimination of the current risk in respect of peer on peer abuse.
• In the interim control measures including additional staffing, two night duty staff, Long Term Safeguarding plans for each resident and Positive Behavioral Support Plan, to ensure residents are being protected from current peer on peer risks.
• A detailed transition plan will be developed to support the transition by 11/01/2019

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Background
RehabCare is fully committed to ensuring the rights of residents are upheld at all times. This encompasses all aspects of resident's lives and influences staff practice at all times.

Actions

• Alternative placement has been identified within RehabCare Services. The resident will be supported to transition by 28th February 2019. This placement will meet the identified individual needs of the resident such as own bedroom/ bathroom/ sitting room/ dining room and 1:1 staffing. This transition will ensure that residents known and consistently expressed will and preference is respected.
• A detailed transition plan will be developed to support the transition by 11/01/2019

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.	Substantially Compliant	Yellow	28/02/2019
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	28/02/2019
Regulation 23(2)(a)	The registered provider, or a	Not Compliant	Orange	28/02/2019

	person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	04/01/2019
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	Substantially Compliant	Yellow	04/01/2019

	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.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/02/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/03/2019
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	28/02/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of	Not Compliant	Orange	28/02/2019

	abuse.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	01/03/2019