Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Rathmore Residential Services
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Announced
Date of inspection:	03 December 2019
Centre ID:	OSV-0003430
Fieldwork ID:	MON-0022529

About the designated centre

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

This designated centre is comprised of three separate houses in relatively close proximity to each other in the same geographical location; a rural village with facilities including a church, post office, shops, a community hall and paved walkways. A maximum of 15 residents can be accommodated and residents present with a diverse range of needs and abilities between the three houses and within the houses themselves. One house is purpose built; all facilities are at ground floor level and are designed and laid out to suit residents with higher needs including physical needs. The majority of residents avail of full time residential services; there is one bed allocated to the provision of respite and six residents avail of the respite service. The provider aims to provide quality person-centred services to each resident in partnership with their family and connected to their community and natural support networks. The staff team is comprised of support staff, social care staff and nursing staff, guided and directed by the person in charge who is also a registered nurse. While the staff skill-mix includes nursing staff, a 24 hour nursing presence is not maintained. The model of care is described as social.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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 - 2015 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
03 December 2019	09:00hrs to 18:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

The inspector visited two of the three houses that comprise this designated centre meeting 14 of the 15 residents. The residents living in this centre are a diverse group; some residents engage in easy conversation while other residents communicate by way of gesture and their general demeanour. Some residents were familiar with the inspector and the work of the inspector from previous inspections of this and other centres operated by the provider. With the exception of residents with higher needs and support requirements, the majority of the residents across the three houses spent their day out of the houses attending a variety of services.

The views expressed by residents as to the centre, staff and the support they received were positive. For example two residents who had transferred from other centres reported that they were very happy in their new home. Equally a resident who was due to transfer to another centre was delighted with this move as the facilities and services provided in the other service were in line with their expressed wishes and preferences. Residents were happy to talk about Christmas and their plans for Christmas whether that was going home to family or staying in the centre. Residents were looking forward to both arrangements including celebrating Christmas in the centre, indicating to the inspector that this was a enjoyable time in the centre. Residents were confident in their environment and with the staff on duty and told the inspector that they would speak up if they were unhappy with any aspect of the service. Residents were aware of the fire safety works that were underway, confirmed they were consulted about them and their impact and were delighted to have the opportunity to redecorate their room once the work was complete. Residents were aware of their own general health and well-being and plans to attend appointments.

Residents confirmed their continued opportunities for community inclusion such as going to mass and attending the local community based day service; two residents were looking forward to and were supported by staff in the evening of the inspection to attend an event in the local credit union.

For residents whose needs were higher and who could not so easily provide such feedback the inspector noted that they had the support that they needed from staff. There was an easy atmosphere and respectful familiarity as staff and residents attended to the normal daily routines of the houses.

Capacity and capability

This inspection was undertaken to follow-up on the findings of an inspection completed in April 2019. The aim of this inspection was to establish the effectiveness of the actions taken by the provider in response to those findings that had not demonstrated a satisfactory level of regulatory compliance. Overall the inspector found that the provider had taken the action that it had committed to and this had impacted positively on the appropriateness, quality and safety of the service. For example there was clarity now on the range of needs that could be met in the centre, work had commenced on supporting residents to live well despite declining cognitive function and an articulated wish from a resident for an alternative placement was about to be realised. However, there were also areas where, while it was evident that the provider had tried to resolve them, they were not satisfactorily resolved due to a lack of completeness in the action taken and the failure to identify that the action taken had not been adequate.

Since the last HIQA (Health Information and Quality Authority) inspection the provider had reviewed the range of needs that could be met in this designated centre. This change was set out in the revised statement and purpose for the service (a record that the provider is required to maintain and sets out information on the range of needs that can be met but also information such as how to make a complaint). This record is an important record and is linked to the registration of each centre. The provider has set out that while one house is purpose built the designated centre cannot accommodate residents with high support medical or nursing needs as a 24 hour nursing presence is not maintained. The provider said it had been unable to secure funding to provide a 24 hour nursing presence.

In line with this change in the range of needs to be met and to support the transparency and objectivity of admission, transfer and discharge decisions the provider had introduced an assessment tool to be completed by two registered nurses. The objective of the assessment was to identify needs including changing needs that were more suited to a nurse led service. However, when the inspector reviewed the providers policy and procedure on admissions, transfers and discharges the inspector found that while it stated that the service had to be suited to meeting resident needs it did not comprehensively set out how the provider established that suitability; for example by using the assessment referenced here. This was of significance to ensure that going forward in the context of the available skill-mix, there was a robust process that ensured good admission and discharge decisions.

The provider had reviewed staffing levels, skill-mix and staffing arrangements to maximise their ability to meet the needs of residents; the provider had undertaken recruitment that was reported to have been successful. Staff spoken with confirmed that they had been consulted with and staffing levels were shortly to increase in one house each morning and at least two evenings each week. Staff were satisfied that this increase in staffing would meet residents increasing need for support and to engage in community based activities of their choosing in the evening.

The provider had sourced and delivered additional training for staff and management. Training had been completed on complaints management, undertaking investigations, the use of restrictive practices, providing fluids and diets

of altered consistency, administering oxygen, the management of seizure activity and promoting psychosocial wellness in ageing. This programme of training reflected inspection findings but also the needs of the current cohort of residents and sought to equip staff with the skills and knowledge to meet these needs. However while staff had attended baseline training in safeguarding and manual handling, a number of staff were due refresher training in both.

The person in charge described the learning gained from training, for example in receiving and managing a complaints. The inspector reviewed the log of complaints received since the last inspection; there was one complaint logged. The complaint record detailed the complaint, how it was responded to, the actions taken in response and how satisfied the complainant was with the management of their complaint. Another longstanding matter related to a complaint from a resident who had sought alternative living arrangements was now at the point of being resolved to the resident's satisfaction. However, the inspector was advised another complaint had been received since the last inspection; there was evidence of how it was addressed in another format (incident review); however, this complaint per-se was not included in the complaints log for the centre.

Failings in the management of accident and incidents had been of concern at the time of the last HIQA inspection. Action taken in response by the provider included a formal monthly review of each incident and its management by a member of the senior management team with the person in charge to ensure that each incident was appropriately responded to. The inspector reviewed the log of incidents and accidents and was satisfied based on the records reviewed that staff acted to ensure resident well-being including seeking medical advice and notifying family for example following a fall.

All of the above reflect the effective action taken by the provider to improve and ensure the appropriateness, safety and quality of service and support provided to each resident. However, there was also evidence that while action had been taken to resolve other matters of safety and quality and this action was considered effective by the provider, the inspector found that it was not. The fact that this HIQA inspection identified these issues shows that oversight and review by the provider including formal reviews undertaken as required by Regulation 23 was not always sufficient to self-identify deficits and ensure that the action taken in response to deficits was effective. The evidence to support this finding is in the cumulative level of non-compliance and will be discussed further in the next section of this report such as the deficits in the application of tools designed to support evidence based care, in the reassessment of residents needs and in the procedures for evacuating residents.

Registration Regulation 5: Application for registration or renewal of registration

While minor clarifications were sought the provider did submit a complete and valid

application seeking renewal of registration of this centre.

Judgment: Compliant

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 who was a registered nurse contributed to the staff skill-mix. The person in charge was satisfied that she had the support needed from the provider to effectively manage the centre. The post of deputy leader had been created and collectively 42 dedicated management hours including weekends was provided for each week.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels, skill-mix and the deployment of staff reflected the revised stated purpose and function of the service and the number and assessed needs of the residents. A planned and actual staff rota was maintained.

Residents received continuity of care and support from a regular staff team.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had attended baseline training in safeguarding and manual handling, however a number of staff were due refresher training in both.

In relation to recommended training the provider needed to satisfy itself that attendance was representative and sufficient to support learning across the staff team.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider submitted evidence that it had contracts of insurance against risks including injury to residents. The contract for care and support agreed with residents advised residents that the provider had such insurance.

Judgment: Compliant

Regulation 23: Governance and management

Oversight and review by management was not always sufficient to self-identify deficits and to ensure that where action was taken in response to deficits it brought about the required change so that residents received a consistently safe, quality service.

The arrangements in place to manage transport required review. Residents living in two houses shared transport and given the number and needs of residents this arrangement was not always suited and did not have capacity at times to meet their needs and choices.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Policy and procedure on admissions, transfers and discharges while it stated that the service had to be suited to meeting resident needs did not comprehensively set out how the provider objectively established that suitability; for example by using the assessment tool introduced to establish the requirement for nursing care.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose contained all of the required information; for example a statement as to the aims and objectives of the centre and the facilities and services to be provided to residents. The record was reviewed and amended to reflect changes such as clarification as to the range of needs that the centre was suited to meeting.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on the records reviewed in the designated centre there were adequate arrangements that ensured that the prescribed notifications were submitted to HIQA, for example any injury sustained by a resident.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints log was not complete and therefore not an accurate record of all complaints received and responded to.

Judgment: Substantially compliant

Quality and safety

As stated in the first section of this report, the provider had made changes to bring about improvement in the appropriateness, safety and quality of the support and care provided to residents. For example the provider had reviewed and agreed the range of needs that could be met in the designated centre and had also enhanced staffing levels. The provider was in the process of completing work to upgrade its fire management systems. Some change for residents had been inevitable, for example the requirement to transition to nurse led services. Positive outcomes for residents currently living in the centre were evident. For example staff confirmed that the increased staffing levels targeted times when residents needed more support from staff and times when they had community activities that they wished to attend. There was however scope for further improvement particularly in ensuring the evidence base of the care and support provided so that residents received optimal care and support based on their assessed and changing needs. There was some delay in residents accessing some healthcare services to which they had been referred. Further work was needed to ensure that the provider's fire safety systems were effective.

The inspector was advised that significant work had been invested in resident's personal plans since the last HIQA inspection. This work was evident in the amount of narrative detail found in the sample of plans reviewed but the detail was also somewhat lost in the amount of information included in the plans. The inspector

found that it was a challenge to find in the plans the evidence for the support and care that was observed. The support observed did not equate with the assessment of needs as the explicit assessment of needs had not been updated and did not accurately reflect changed and increased needs. This meant that on initial reading of the support plan it did not reflect current needs and current support requirements. In addition there was duplication of plans of support that could have been amalgamated for ease of use and update by staff. For example a requirement for wheelchair transfer was not referenced in the assessment of need or the plan to support mobility but was found in a plan to support falls prevention. Greater oversight of the plans was needed to ensure that a residents requirement or request for support was clearly understood as was the impact of one need on another area of support; for example the impact of cognitive decline and visual impairment on the ability to mobilise or the potential impact of medicines prescribed on an as needed basis on diminished respiratory capacity. In addition the inspector found that tools used and that should promote an objective, evidence base to the care and support provided were incomplete or incorrectly completed, for example in relation to assessing a residents risk of falling or assessing whether it was safe and appropriate to use a bed-rail. All of these findings demonstrated non-compliance with regulatory requirements but also had the potential to create risk to the appropriateness, safety and quality of the care and support provided to residents. On balance the inspector was able to find the rationale for the support and care observed, for example the observed wheelchair transfer and where a diet of a modified texture was provided.

In relation to the use of a restrictive practice specifically the use of bed rails, there was a requirement to ensure that the assessment tool used to inform decision-making was correctly completed at all times. It was not and therefore did not demonstrate how it informed the decision to use the bed rail; its lack of completeness did not adequately demonstrate that this was the correct and safest decision. Again however on balance records requested by the inspector in relation to the recent introduction of a chemical intervention demonstrated that staff understood the principle of last resort and minimal intervention. The frequency of administration of the medicine was not of concern, the maximum permitted dose was not administered and review of the intervention was scheduled.

The inspector saw evidence of support and care that sought to develop and maintain resident psychosocial well-being. For example the majority of residents living across the three houses attended off-site day services each day Monday to Friday. One resident was accessing the local community day service; this was a new initiative for this centre, had been positively supported by the local community and built on the community inclusion and integration that residents living in this centre enjoyed. The psychologist was actively working with residents and staff in developing daily programmes that maintained purposeful engagement, a sense of self, functioning and relationships for residents now experiencing cognitive decline. Residents were invited and supported to participate in national disability initiatives, for example developing material that supported explanation of national screening programmes. For the majority of residents being out and about in the community, having contact with family, and maintaining contact with friends and peers maintained their sense of self and satisfaction with life.

As stated earlier in this report the provider had redefined the range of needs that could be met in the designated centre and had structured and targeted the available nursing resources so as to better meet residents assessed needs. The inspector also saw that residents had access to their General Practitioner (GP), neurology, older person's specific services and to national health screening programmes; staff used indicators such as body weight and vital signs to monitor resident well-being. However, there was some evidence confirmed by the person in charge that residents following referral did not always have timely access to the requested healthcare service.

The provider was seeking to improve its compliance with fire safety requirements. A programme of work was underway in one house to bring the existing fire containment measures and the facilities to support the evacuation of residents up to the current required standard. The provider has a plan and a time-frame for the timely completion of these works but they are not yet complete. Residents confirmed that the replacement fire-resistant doors presented no difficulties for them but the inspector did see that door-wedges were used. Staff described their management so that they did not impede the purpose of the doors but an explicit protocol was required for their use if they were actually needed, for example to hold a door open to allow for observation.

In the house where the greatest number of residents with the highest of needs resided the inspector saw that while action had been taken to improve evacuation procedures it was not demonstrated that the desired objective was met. Devices to assist in the evacuation of dependent residents had been provided and 20 staff had completed training in their use; each residents PEEP (Personal Emergency Evacuation Plan) had been updated to include the use of this device. The PEEPS indicated that the evacuation device was in use for over half of the residents living in this house. Simulated drills had been completed using the principle of progressive horizontal evacuation. However, while these drills reflected the introduction and use of these evacuation devices they did not adequately test the effectiveness of the provider's evacuation plan. For example no record seen represented a scenario of minimum staffing and maximum occupancy. The fire evacuation plan was displayed and while it contained most of the required elements such as raising the alarm and alerting the fire service; it did not reflect the pre-determined plan of progressive horizontal evacuation and the requirement of the provider to have adequate arrangements for the evacuation of all persons from the designated centre.

Regulation 13: General welfare and development

There was strong evidence of community inclusion and participation and of maintaining and developing friendships and relationships in a very ordinary way. Residents' accessed community based services and amenities on an almost daily basis. Residents had ongoing access to family and home, peers and friends. Goals to

guide care and support sought to maintain functioning, meaningful engagement, personal and social relationships for residents as ability declined.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had reviewed its procedures and had put oversight in place to ensure that incidents involving residents were appropriately identified, responded to and reviewed so as to promote resident safety and safeguard residents from harm.

Judgment: Compliant

Regulation 28: Fire precautions

A programme of work was underway in one house to bring the existing fire containment measures and facilities to support the evacuation of residents up to the current required standard. The provider had a plan and a timeframe for the timely completion of these works but they were not as yet complete.

Simulation evacuation drills did not adequately test the effectiveness of the provider's evacuation plan. No record seen represented a scenario of minimum staffing and maximum occupancy. The fire evacuation plan was displayed and while it contained most of the required elements such as raising the alarm and alerting the fire service it did not reflect the pre-determined plan of progressive horizontal evacuation and the requirement of the provider to have adequate arrangements for the evacuation of all persons from the designated centre.

An explicit protocol was required for the use of door wedges if they were actually needed, for example for observation purposes.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Resident needs and hence their support requirements had changed but the explicit assessment of needs had not been updated and did not reflect these changed and increased needs.

There was duplication of plans of support that could have been amalgamated for ease of retrieval of the relevant information and for ease of use and update by staff. It was a challenge to find in the plans the evidence for the support and care that was observed.

Greater oversight of the plans was needed to ensure that a residents requirement or request for support was clearly understood as was the impact of one need on another area of support. Tools used and designed to promote an objective, evidence base to the care and support provided were incomplete or incorrectly completed and therefore did not demonstrate how they informed the evidence base of the care and support provided.

Judgment: Substantially compliant

Regulation 6: Health care

Residents did not always have timely access to the requested health care service after health care referrals were made .

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There was a requirement to ensure that the assessment tool used to inform decision-making was correctly completed at all times. It was not and therefore did not demonstrate how it informed the decision to use the bed rail; its lack of completeness did not adequately demonstrate that this was the correct and safest decision.

Judgment: Substantially 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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Rathmore Residential Services OSV-0003430

Inspection ID: MON-0022529

Date of inspection: 03/12/2019

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training on manual handling for 3 staff is scheduled for Tuesday January 21st 2020.Safeguarding vulnerable adults at risk of abuse is scheduled for 23/01/2020 and 20/02/2020. The PIC will monitor training for staff to ensure that all staff have access to mandatory and appropriate training.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Over the next 6 months an additional provider audit will be completed by different personal and within 12 months a provider audit will be completed in the designated center by two Assistant Directors of services. At present in the designated centre association transport is shared between two houses within the designated centre, however either house has access to a private transport company since April 2019 over a 7-day week to support planned events and outings, this has proven to be very successful and there have been limited occasions where the private has not been available. We will continue to avail of this service, however additional association transport has been requested for the designated centre, Rathmore residential services is prioritized for new transport.	

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The admissions, transfer and discharges policy will be reviewed and any assessments that are currently in use within the organization will be referenced and attached to the policy. This will ensure that each admission to the designated centre is determined on the basis of transparent criteria and in accordance with the Statement of Purpose.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaint referenced has been assigned to the designated centre, this will be reviewed by the PIC and the ADOS.The PIC will ensure that all complaints are held on the register in the designated centre and that all actions, investigations and outcomes are monitored by the senior team.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The fire works in one house has been completed since 23/12/2019.
A protocol in relation to the use of door wedges is now in place, the associated risk assessments will be reviewed and updated to reflect same.
A competent person will demonstrate a simulated drill with minimum staff and maximum residents, staff will practice simulated drills over the next 12 months. The fire evacuation plan will be updated to reflect the use of progressive horizontal evacuation.
The staff will continue to receive annual training in fire safety.

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:
The assessment of need will be reviewed and updated where applicable and all care plans will be reviewed where applicable to reflect individual's currents supports and care required, while identifying any changing need. This will be completed by resident's key workers with support from the Clinical Nurse Specialist and the PIC. Any tools currently being used within the residents care plans will be brought to the Quality and Standards meetings and will be reviewed and updated accordingly.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
There is currently one outstanding referral for an individual, due to a delay from the required health service, this is now being sourced privately.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The assessments in relation to the use of bedrails will be reviewed by the PIC, restrictive practices committee will review all restrictive practices in relation to the use of bedrails, every effort will be made to safely remove the bedrail. One chemical restraint has been reviewed as scheduled on 19/12/2019 and has been discontinued.

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 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.	Substantially Compliant	Yellow	28/02/2020
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	28/11/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Not Compliant	Orange	26/07/2020

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Substantially Compliant	Yellow	28/02/2020
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	23/12/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	28/02/2020
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, outcome of a complaint, any action taken on foot of a complaint	Substantially Compliant	Yellow	14/01/2020

	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.	Substantially Compliant	Yellow	31/01/2020
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/01/2020
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, which review shall assess the	Substantially Compliant	Yellow	31/01/2020

	effectiveness of the plan.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	31/03/2020
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.	Substantially Compliant	Yellow	31/01/2020