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:	Teach Michel Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	12 April 2023
Centre ID:	OSV-0005700
Fieldwork ID:	MON-0039880

About the designated centre

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

Teach Michel Services is designated centre run by Ability West. The centre provides full-time residential service for up to six people with an intellectual disability, who are over the age of 18 years. The centre is located close to Galway city and comprises four fully self-contained apartments. Residents have their own bedroom, living area, kitchen and bathrooms. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 12 April 2023	09:30hrs to 13:30hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced risk inspection carried out to assess the provider's compliance with specific regulations. The Chief Inspector had received information which raised specific concerns about staffing levels, residents rights and general welfare as well as overall governance and management of the centre. The provider had also recently notified the Chief Inspector of their plans to temporarily move two residents to another designated centre due to the providers inability to maintain adequate staffing and ensure the safety and welfare of residents in the centre. This information together with previous inspection findings has given rise to serious concerns regarding staffing arrangements and the safety and welfare of residents in this centre.

Teach Michel is located in a residential area close to a city. It is a two-storey building and comprises of four apartments. Two apartments are located on the ground floor and two apartments are provided on the first floor. On the day of inspection, there were five residents living in the centre. Three residents were accommodated in individual apartments and two residents shared another apartment. This inspection was based in two of the apartments as the concerns raised related to the impact of inadequate staffing on the care and welfare of the two residents who were residing there. The inspector met and spoke with one of the residents as well as with staff supporting both residents on the day of inspection.

On arrival at the centre, the inspector met with the care assistant who was on duty in one of the apartments and later met with the unit director and another staff member who was on duty in the second apartment. Staff advised the inspector that there was still no person in charge appointed in the centre. Staff reported that residents had not been moved to the respite services as planned. Staff advised that following discussion, the respite service staff team had agreed to provide staffing support for both residents for a interim period at Teach Michel. They outlined how this arrangement was in the best interests of both residents in terms of stability and their safety and welfare. However, they also outlined their concerns regarding the number of staffing vacancies, staff burn out from working long and extended hours, and the ongoing uncertainty with regard to staffing as they believed that the current arrangement was temporary.

The inspector met with the resident in the first apartment visited. They were in good form and were happy to show the inspector around the apartment. The apartment had been recently repainted and found to be bright, warm and comfortable. The inspector noted a damaged and broken toilet cistern, however, it was being replaced during the inspection. Staff reported that there was a noted improvement in the response times by the maintenance team to reported issues. The resident spoke about looking forward to their upcoming birthday plans, about how they enjoyed watching music videos on their hand held computer tablet and quiz shows on the television. They showed the inspector the new large screen smart television which had been provided in the living room. They also mentioned how they enjoyed

regular walks, swimming sessions and playing soccer. Throughout the morning of the inspection the resident appeared to have a good rapport with staff as they interacted in a friendly and familiar manner. Staff were observed to respond to all requests for support and provided reassurances for the resident in response to their queries. The resident appeared content in their environment as they went about their usual morning routines. During the morning time, the behaviour support therapist visited the resident as planned as they had arranged to have breakfast. Later in the morning, the resident with the support of the behaviour therapist and another staff member went out for the day to partake in planned activities.

The inspector also visited and spoke with staff in another apartment. The inspector did not meet with the resident as staff advised that they would not be comfortable in meeting with the inspector. The apartment was found to be bright, clean and comfortable. The residents artwork was framed and displayed in the hallway. The staff member on duty confirmed that the resident was now supported by a staff member at all times. They reported that staffing in this apartment was now more stable with three full-time staff currently available and another due to return to work later in April. However, they confirmed that there had been occasions during the recent past when the staff member on duty had to leave this apartment in order to administer medications to residents in other apartments as the agency staff on duty did not have the required training to administer medications. The staff member on duty reported that the resident was supported to get out and about and partake in his preferred activities on a daily basis.

Visiting to the centre was being facilitated in line with national guidance. Residents were supported to receive regular visits from their family members. Residents were also supported to remain in contact with their family through the use of their mobile telephones. One resident spoke of regular visits to his family.

Overall the inspector found that the regular staff working in the centre were knowledgeable regarding the residents needs, were very dedicated to meeting those needs and ensuring that the residents quality of life had not been impacted upon. They reported working additional hours including up to 60 and 70 hours over the past weeks but advised that this was not sustainable. The provider did not have effective governance and management arrangements in place, had not appointed a suitably qualified person in charge of the centre, had failed to ensure that the centre was resourced properly, had inadequate oversight of risk management to ensure risks were identified and acted upon to ensure residents were consistently safe.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents life.

Capacity and capability

The provider had not ensured there were effective management systems in place to ensure that the service provided was safe, consistent and appropriate to the needs of the residents. The provider had not ensured that the centre was resourced in terms of staffing to ensure effective delivery of care and support for all residents. The provider had failed to appoint a person in charge to manage the centre. The provider had failed to fully implement its own compliance plan submitted to the Chief Inspector following the last inspection. Improvements were still required to risk management systems to ensure that risks were identified and acted upon to ensure residents were consistently safe. Further oversight was still required in relation to medication management and restrictive practices which had been identified during the last inspection in October 2022.

The person in charge had vacated the post in September 2022 but the provider had failed to appoint a new person in charge in line with the regulations. The provider had put in place interim arrangements for a unit director with the support of the assistant director of client services to oversee the service. However, the unit director had no allocated hours to this operational management role and due to the recent staffing shortages had been working extended hours on the floor and therefore was unable to full fill this role.

The centre was not adequately resourced in terms of staffing to ensure effective delivery of care and support for all residents. Staffing shortages have been an on-going challenge for this service over several months. Staff advised that these concerns had been escalated to the senior management team, who in turn had raised these concerns with the Health Service Executive (HSE). A number of staff from four different external agencies had been rostered in response to the crisis. However, staff reported that these arrangements had been unsatisfactory due to the constant changing of staff, inadequate training of some agency staff and due to the need for some residents with complex needs requiring consistency of staff. They outlined how the constant changing of staff had led to an increase in behaviours of concern and anxiety for some residents.

At the time of inspection, the staff team from one of the respite services had agreed to provide staffing support for residents for a short period at Teach Michel. These respite staff members were undergoing induction training and were working a number of 'buddy' shifts with full-time staff. However, on review of the roster for the coming weeks there were still many gaps noted. There were 10 shifts where no staff member was identified for the week of the 24 April 2023. The unit director reported that it was a challenge to get adequate staff to cover all shifts. While staff from the respite services had agreed to support Teach Michel, they normally worked a different shift pattern and were not available during the day time. On the day of inspection, the inspector noted that the unit director made several phone calls enquiring as to staff availability for the evening shift. While the unit director confirmed that there were always two staff on duty in one of the apartments apartments during the day time to support the resident who was assessed as requiring 2;1 support, there were now only two full-time Teach Michel staff available to support this resident. Staff members on duty on the day of inspection reported having worked between 67 and 70 hours the week previous and raised concerns

regarding the ongoing uncertainty with regard to staffing as they believed that the current arrangement with the staff team from the respite service was temporary and for the short term only.

While the provider had carried out a review on the quality and safety of care in the centre during December 2022 and had identified many areas for improvement including health and safety, risk management, safeguarding and safety, there was no evidence to date that these issues had been discussed with staff or to show what action was being taken to address the issues identified. The risk register last review date was February 2023, however, risks including those associated with having no person in charge, agency staff, lack of administration hours for the unit director were not identified and included. Staffing and skill mix identified as a medium risk was in appropriately risk rated given the on-going staffing crisis and concerns raised.

Arrangements in place to ensure that staff were supported and facilitated to raise concerns about the quality and safety of care and support provided to residents still required review. The provider had failed to fully implement its own compliance plan following the last inspection whereby they had committed to monthly staff meetings. Staff spoken with and records of staff meetings reviewed indicated that there had been no staff meetings in recent months. Records showed that the last staff meeting took place in November 2022 when the staffing crisis was listed as a agenda item. Staff also raised their concern that the provider had no protocol in place if and when sleepover duty at night time changed to active night duty due to residents support needs. Staff reported that they sometimes had to work full days following active duty at night time which posed a risk to residents.

Staff confirmed that there were now on-call management arrangements in place for out of hours seven days a week. Staff were made aware of the arrangements on a weekly basis and reported that there was a dedicated phone number for contacting the on-call management team member. The on-call arrangements were displayed in the centre.

Regulation 14: Persons in charge

The provider had not appointed a full-time person in charge with the required experience and qualifications to manage the centre as required by the regulations. The post of the person in charge has been vacant since September 2022. The unit director appointed to manage the centre in the absence of the person in charge had no allocated hours to full fill this operational management role.

Judgment: Not compliant

Regulation 15: Staffing

The provider had not ensured that the number and skill mix of staff was appropriate to the number and assessed needs of residents. There was ongoing uncertainly and concern regarding staffing arrangements in the centre.

There were currently many staffing vacancies with seven staff members having left their posts over the past number of months.

There were many gaps noted in the planned staff roster for the coming weeks. There were 10 shifts where no staff member was identified for the week of the 24 April 2023.

Some staff members reported having worked between 67 and 70 hours the week previous which is not sustainable.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not ensured there were effective management systems in place to ensure that the service provided was safe, consistent and appropriate to the needs of the residents.

- The provider had not ensured that the centre was resourced in terms of staffing to ensure effective delivery of care and support for all residents.
- The provider had failed to appoint a person in charge to manage the centre.
- The provider had failed to fully implement its own compliance plan submitted to the Chief Inspector following the last inspection.
- Improvements were still required to risk management systems to ensure that risks were identified and acted upon to ensure residents were consistently safe.
- Further oversight was still required in relation to medication management and restrictive practices which had been identified during the last inspection in October 2022.

Judgment: Not compliant

Quality and safety

Staff on duty on the day of inspection strived to ensure that residents received an individualised and good quality service. Despite the on-going staffing crisis, the remaining staff had worked many additional hours to ensure that residents continued to get out and about in the community and attend their preferred

activities on a daily basis. However, as discussed under the capacity and capability section of this report, improvements required to the governance and management arrangements and the lack of consistent and adequate staffing impacted negatively upon the quality and safety of the service provided.

Staff spoken with were familiar with and knowledgeable regarding residents up to date health care needs. Support plans were in place for all identified issues and were found to be individualised, informative and person centered. Residents assessments and care plans were generally found to have been recently reviewed and updated, however, the quality of life care plan was not dated or signed, therefore, the inspector could not be assured that the information and guidance was up-to date and reflective of the residents current care and support needs. This had been identified during the previous inspection. Staff were very knowledgeable regarding specific dietary support needs for a resident and reported how this residents dietary needs were being well managed. Recommendations from the speech and language therapist (SALT) and dietitian were clearly outlined and informed the support plans in place.

Residents had access to General Practitioners (GPs), out of hours GP service, consultants and a range of allied health services. Residents had also been supported to avail of vaccination programmes. Files reviewed showed that residents had an annual medical review.

The inspector reviewed a residents personal plan dated January 2023 which clearly set out their chosen goals. The personal plans had been developed in consultation with the resident, family members and staff. The plan was available to the resident in an easy read accessible format. Staff reported that the resident had achieved all their goals during 2022 and some goals such as going swimming had already been achieved during 2023. While staff updated the inspector on the progress of these goals and there was some photographs on file for 2022 showing the resident achieving some of their desired goals, there was no system in place to formally record the progress and effectiveness of individual goals. This had also been identified at the previous inspection.

The inspector noted that while some non compliance's identified in relation to medicines management had been addressed, the provider had failed to fully implement its own compliance plan in relation to issues identified during the last inspection. Further improvements were still required to reflect best practice and to ensure that the centres own medication management policy was being implemented. Medicines were stored securely. A review of a sample of medicine prescribing and administration charts showed that medicines were being administered as prescribed. There were systems in place for the return of out-of-date or discontinued medicines to the pharmacy, there were now systems in place for checking medicines on receipt from the pharmacy. The pharmacist had completed an medications audit in November 2022 and no issues of concern had been identified. Systems in place for the recording of controlled medicines still required review. Staff had continued to maintain a tracker sheet which included stock balance and signed by two staff, however, the Misuse of Drugs Acts (MDA) drug register was still not in use as required by the medication management policy.

The inspector along with the staff member of duty completed a stock balance check of a prescribed MDA drug and balances were found to be correct. Following the last inspection, systems had been introduced for weekly stock checks on other medicines, however, these checks had not been recorded since 8 February 2023. The unit director advised that due to lack of staffing resources it had been difficult to ensure that checks and records were kept up-to-date.

Residents who required supports with behaviours of concern had a comprehensive support plans in place. There was evidence that support plans had been reviewed and updated in consultation with staff, the behaviour support therapist and multidisciplinary team. The plans outlined clear guidance for staff regarding the possible triggers, proactive strategies, early warning signs and management of escalation of behaviours. Staff spoken with confirmed that all staff including staff temporarily assigned from the respite services had received training in the management of behaviours and had experience in managing behaviours of concern. Staff spoken with also confirmed that staff from the respite services had been updated and informed regarding behaviour support plans in place as well as all protocols in relation to the management of restrictive practices as part of their induction training.

The inspector noted that while improvements were noted to the management of restrictive practices including written protocols and systems in place for the administration of PRN 'as required' medications, the provider had failed to fully implement its own compliance plan in relation to all issues identified during the last inspection. Improvements were still required to the oversight and management of some restrictive practices to ensure such procedures were used in accordance with national policy and evidence based practice. For example, there was still no written protocol in place for the use of a visual monitor in a residents bedroom.

Regulation 26: Risk management procedures

Improvements were required to risk management systems to ensure the assessment, management and on going review of risk in the centre. Further oversight was required to ensure that risks were identified and acted upon to ensure residents were consistently safe. The risk register was not up-to-date. For example, there were no risks identified in relation to the vacant post of person in charge, lack of administration hours for the unit director, external agency staffing arrangements and staff temporarily assigned from another service. Other risks identified as a medium risk such as staffing and skill mix were inappropriately risk rated given the on-going staffing crisis and concerns raised.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had failed to fully implement its own compliance plan in relation to issues identified during the last inspection. Further improvements were still required to reflect best practice and to ensure that the centres own medication management policy was being implemented. The Misuse of Drugs Acts (MDA) drug register was still not in use as specified in the medication management policy. Weekly stock checks of medicines or the monthly audits on medicines were not being completed as advised in the providers compliance plan response to the last inspection report.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Some issues identified during the last inspection had still not been addressed. For example, a quality of life care plan was not dated or signed, therefore, the inspector could not be assured that the information and guidance was up-to date and reflective of the residents current care and support needs. There were still no systems in place to formally record the progress and effectiveness of individual goals set by residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had failed to fully implement its own compliance plan in relation to all issues identified during the last inspection. Improvements were still required to the oversight and management of some restrictive practices to ensure such procedures were used in accordance with national policy and evidence based practice. For example, there was still no written protocol in place for the use of a visual monitor in a residents bedroom.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Teach Michel Services OSV-0005700

Inspection ID: MON-0039880

Date of inspection: 12/04/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: There are and have been ongoing recruitment efforts to recruit a Person in Charge for Teach Michel. Our objective is to have a Person in Charge in place by 30th June 2023. As an interim measure until the Person in charge is appointed, the Person Participating in Management will continue to deputise as the Person in Charge with support from the Team Leader. In May 2023, one of the residents in Teach Michel has relocated to another designated centre, and so the management structure and allocated hours to Teach Michel have been updated to reflect this change in operational management.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In May 2023, one of the residents in Teach Michel relocated to another designated centre, which has eliminated the significant staffing gaps in the roster in Teach Michel Currently there are no staffing issues or vacancies in Teach Michel The management structure in the team ensures that all staff receive adequate breaks and time off, and that residents have a consistent quality of support from a consistent staff team. Staff are supported and supervised in their role and trained in the effective delivery of care daily. The roster is reviewed and updated weekly by the Person participating in Management and the Team Leader. Monthly staff meetings continue to take place with the staff team and there is a schedule of meeting dates within the Centre.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Person in Charge	

Currently we are recruiting for a person in charge for Teach Michel and will have a person in charge in place by 30th June 2023
As an interim measure until the Person in charge is appointed, the Person Participating in Management will continue to deputise as the Person in Charge with support from the Team Leader

Staffing Resource:

In May 2023, one of the residents in Teach Michel has relocated to another designated centre, which has eliminated the significant staffing gaps in the roster in Teach Michel

Currently there are no staffing issues or vacancies in Teach Michel

The management structure in the team ensures that all staff receive adequate breaks and time off, and that residents have a consistent quality of support from a consistent staff team.
Staff are supported and supervised in their role and trained in the effective delivery of care daily. The roster is reviewed and updated weekly by the Person participating in Management and the Team Leader.
Monthly staff meetings continue to take place with the staff team and there is a schedule held within the Centre.

Compliance Plan Update
Monthly staff team meetings are now in place for the staff team in Teach Michel . HIQA and PLA inspections with clearly identified actions and updates are discussed at this staff meeting

Weekly Resident meetings take place with clearly identified actions and minutes.
A quality enhancement plan is in place and reviewed and updated on a regular basis by the Person Participating in Management and Team Leader.

Risk Management
The Person Participating in Management along with the Team Leader have reviewed specific risks within the Centre and updated the Risk Register to ensure it accurately reflects the current risks identified and assessed.
The risk rating for some risks within the Centre has been amended as necessary.
Risk Training has taken place for the person participating in management and team leader in April 2023.
Risk training to take place for all staff by the end of June 2023.
The Person participating in management and Team Leader are working with the Positive Behaviour Support Team to ensure all restrictive practices are identified appropriately and recorded to ensure that least restrictive measures are in place at all times and effective protocols in place for all restrictions to guide best practice. These will be finalized by 19th June 2023.
The restrictions in place will be referred to and monitored via the organizational Restrictive Practices Committee at regular Restrictive practices review meetings that are scheduled for the remainder of the year

Medication Management
Medication practices within the Centre now ensure adequate recording and auditing of medications in line with policy and The Misuse of Drugs Acts (MDA).

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Person Participating in Management and Team Leader have reviewed risks within the Centre and amended the risk register to ensure it accurately reflects the current risks within the Centre, to include the absence of a Person in Charge. The risk rating for some risks within the Centre has been reviewed and amended as necessary.
The risk register will continue to have oversight by the Person Participating in Management and the Team Leader at regular support meetings.
Risk Management training has taken place in April 2023 for the person participating in management and the Team leader.
Risk management training for the staff will take place by the end of June 2023

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Centre now has a drug register in place to ensure they are meeting the requirements under The Misuse of Drugs Acts (MDA).

The Centre is also ensuring that they are following Ability Wests medication policy and ensuring that medication stock takes are carried out weekly and monthly as required.

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 Residents personal plan have been updated to clearly show progress in relation to personal goals. All documents within the Residents personal plan have been reviewed clearly showing dates of completion and review dates and there is a system in place to assess the effectiveness of progress in goals set out by Residents.
Needs assessments for all residents is currently being reviewed by the key workers and verified by the MDT team and this will be completed by 2nd June 2023

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The team are currently working with Positive Behavioural Support to ensure that all restrictive practices are recorded accurately with adequate protocols in place to guide staff team in best practice and meet national standards. All restrictions will be reviewed as required by the restrictive practices committee and approved as appropriate at scheduled meetings for the remainder of the year.

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 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	30/06/2023
Regulation 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	30/06/2023
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is	Not Compliant	Orange	12/04/2023

	appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
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	12/04/2023
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	31/08/2023
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	31/07/2023

Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Not Compliant	Orange	31/07/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	28/04/2023
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	28/04/2023

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	31/07/2023
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	31/07/2023