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:	Avalon
Name of provider:	Redwood Extended Care Facility Unlimited Company
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	30 January 2024
Centre ID:	OSV-0002433
Fieldwork ID:	MON-0033460

About the designated centre

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

The designated centre provides residential services to adults 18 years and over, who present with a diagnosis of intellectual disability, autism or acquired brain injury and may also have mental health difficulties and behaviours of concern. The centre can accommodate five residents both male and female. It is fully wheelchair accessible, each resident has their own bedroom and there is one self contained apartment. The centre includes a kitchen, utility, dining room and four communal living areas. There are garden areas available to residents. The centre is located on the campus of the organisation, a short distance form the nearest village. The centre is staffed by a person in charge and staff team, with access to nursing staff at all times.

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
Tuesday 30 January 2024	10:00hrs to 19:00hrs	Julie Pryce	Lead
Tuesday 30 January 2024	10:00hrs to 19:00hrs	Sarah Barry	Support

What residents told us and what inspectors observed

This inspection was conducted in order to monitor on-going compliance with regulations and standards and to help inform the registration renewal decision.

On arrival at the designated centre, the inspector found that residents were going about their day, some people were leaving for outings and others were engaged in activities in their home. The inspector conducted a 'walk-around of the centre, and found that there were multiple communal areas, and that the home was decorated and maintained to a good standard.

Each resident had their own room, and these were decorated and furnished in accordance with their preferences. One of the rooms appeared to be quite sparsely furnished, however, the person in charge explained that this was the choice of the resident, and that they were happier with their room being as it was. They had clearly chosen the paint colour of the walls of their room, and there was a large mural depicting one of their favourite activities.

Not all residents were willing to meet or interact with the inspector, so the inspector reviewed documentation, spoke to staff and made discreet observations. Of those residents who did meet with the inspector, they mentioned their interests, and showed the inspector some items of relating to their favoured activities. The inspector observed that they were very comfortable with the staff member who was accompanying them, and that the interactions were familiar and caring in nature.

One resident had a self-contained apartment, and accepted a brief visit from the inspector. The apartment was decorated and furnished as the resident chose, and was full of their possessions and preferred items, all of which were stored in the way the resident preferred.

Staff members spoke with confidence about the care and support needs of residents, and described in detail the actions they would take in various different circumstances, including in the management of behaviours of concern. They spoke about the improvements they had observed in the behaviour of some residents following the implementation of behaviour support plans, and spoke about the increased opportunities that had then become available to residents, such as accessing community locations and events.

Staff had all received training in human rights, and spoke about the ways in which they ensured that residents' choices and preferences were listened to, and the steps they were taking to ensure the rights of residents were upheld. They spoke about positive risk taking and supporting residents' rights to make decisions and to engage in more risky activities. One resident had been supported to go swimming, which had previously been a high risk activity for them, and another had started go-carting. These increased opportunities were documented, and the records were

available for review by the inspector.

The inspector had the opportunity to meet some of the residents' family members on the day of the inspection. Relatives said that their family members felt safe and happy in their home, and one relative said that it was very clear that they were happy because, there had been such a significant reduction in the number of incidents involving their relative. They said that much of this was down to the leadership of the person in charge, and the staff team who they said, knew their relative very well, and could immediately pick up on any cues or signs, and responded immediately and appropriately.

Relatives spoke about the way residents were introduced to new opportunities, both for learning and for leisure. One family member said that they knew that their relative felt safe and content because, their sense of humour was returning, and another said that the admission of their relative to the designated centre was 'life changing'.

Overall residents were supported to have a comfortable and meaningful life, with an emphasis maintaining and increasing opportunities for each resident, and that there was a good standard of care and support in this designated centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective both in relation to monitoring practices, and in quality improvement in various areas of care and support.

There was an appropriately qualified and experienced person in charge who was supported by a house manager and a daily shift leader.

There was a competent and consistent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents. Staff were appropriately supervised both formally and on a daily basis.

Information required in staff files was available for the most part, although improvements were needed in ensuring that, appropriate staff references were submitted prior to the commencement of employment.

There was a clearly defined complaints procedure in place which was readily available to residents and their families and friends.

Registration Regulation 5: Application for registration or renewal of registration

All the required information was submitted with the application to renew the registration of the designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was appropriately skilled and experienced, and was involved in the oversight of the centre, and in quality improvement of care and support offered to residents.

Judgment: Compliant

Regulation 15: Staffing

Both the staffing numbers and skills mix were appropriate to the number and assessed needs of the residents. Some residents required 1:1 staffing, and this was facilitated. The person in charge had the flexibility to roster additional staff to meet the needs of residents in relation to either, social activities or appointments. A planned and actual roster were maintained in accordance with the regulations.

There was a consistent and competent staff team in place, and all staff engaged by the inspector were knowledgeable about the care and support needs of residents.

A sample of staff files was reviewed by the inspectors, and they were found to contain the information required by the regulations for the most part. However two of the staff files did not include a reference from the previous employer of the staff members. These references were presented to the inspectors prior to the close of the inspection, however, they were dated for the month of the inspection, so that there was no evidence that these had been obtained prior to the commencement of employment. This practice did not provide assurance that recruitment practices were robust or effective.

Judgment: Substantially compliant

Regulation 16: Training and staff development

All mandatory training was up to date, and staff were in receipt of additional training regarding some of the particular assessed needs of residents, including epilepsy awareness and behaviour support. Staff had also received training in assisted decision making and in human rights. The organisation's human resources department had recently undertaken an audit of staff training to ensure that all training was up-to-date.

Staff were supervised on a daily basis and a schedule of staff supervision conversations was in place. These supervision conversations took place quarterly, and a record of their completion was maintained.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 22: Insurance

Appropriate insurance arrangements were in place.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and their reporting relationships.

An annual review of the care and support offered to residents had been completed as required, and this document was detailed and included the views of the resident and their family. Six-monthly unannounced visits on behalf of the provider had been undertaken, and any identified actions from these processes were monitored until complete.

In addition a monthly schedule of audits was in place, including audits of residents' rights, premises and infection prevention and control. These processes all identified any required actions for improvement, and these actions were monitored until

complete.

Communication with the staff team was structured and effective via a system of team meetings, a detailed handover system, and daily communication diary. Staff meetings were conducted every month over two days to ensure the maximum attendance of staff.

Any accident and incidents were reported and recorded appropriately, were overseen by management and were discussed at the regular team meetings.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

There were contracts of care in place for each resident which included all the required information. These contracts had been made available to residents in an easy read version, and each had been signed by the resident.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service.

Judgment: Compliant

Regulation 31: Notification of incidents

All the required notifications had been submitted to the office of the Chief Inspector, including notifications of any incidents of concern.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure available to residents and their friends and families. The procedure had been made available in an easy read version. There

were no current complaints.

Judgment: Compliant

Regulation 4: Written policies and procedures

All the policies required under schedule 5 of the regulations were in place, and all were reviewed within a three year timeframe.

A sample of these policies was reviewed by the inspectors, including the policies on risk management and safeguarding. These policies were evidence based and provided information and guidance to staff.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that the care and support needs of each resident was met. Each resident was supported to have a meaningful day, and there was evidence of improving outcomes for residents.

There was an effective personal planning system in place which involved residents and their families. Residents were supported in increasing their opportunities and experiences. Healthcare was effectively monitored and managed and changing needs were responded to in a timely manner

Where residents required positive behaviour support there were plans and risk assessments in place, and staff were familiar with them, although improvements were required in the documented guidance for the use of 'as required' (PRN) medication in relation to behaviours of concern. Any restrictive interventions were kept under constant review, and there was evidence of the reduction in the use of restrictions as soon as it was safe to do so.

Fire safety equipment and practices were in place to ensure the protection of residents from the risks associated with fire. There was clear evidence that residents could be evacuated in a timely manner in the event of an emergency, although some improvements were required in the documented guidance for staff. There were risk management strategies in place, and all identified risks had effective management plans in place.

Medication management was safe and appropriate for the most part, with some improvement being required in the oversight of stock control for some medications.

The rights of the residents were well supported, and the preferences and choices of residents were discussed and documented, and there was evidence of supports being put in place to ensure that their voices were heard.

Regulation 13: General welfare and development

Residents were supported to have a meaningful day in the ways that were individual to them. There were multiple experiences and opportunities being made available to them. Staff supported activities and hobbies, and respected the wishes of residents as to how they spent their time. Some people preferred doing things at home, such as sensory activities, whilst others preferred more outdoor pursuits, and were involved in activities including horse riding and walking.

Residents had been supported to maximise their potential both by being supported in activities, and in support for managing behaviours of concern to that more opportunities were available to them. Family members discussed with the inspector the significant improvements they could see in the outcomes for their relatives.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared a guide in respect of the designated centre and ensured that a copy was provided to each resident. This guide included all the information required by the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a current risk management policy which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to residents. There was a risk assessment and risk management plan for each of the identified risks. Local and environmental risks managed under this system included safeguarding, infection prevention and control and the management of sharp implements.

Staff were aware of all the identified risks in the designated centre, and could explain their role in the management and mitigation of risks.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. There were self-closing fire doors throughout the centre and all equipment had been maintained. Regular fire drills had been undertaken, and the person in charge ensured that, all staff had been involved in a drill, including any new staff.

There was a fire safety policy in place which outlined the responsibilities of the shift leader, outlined the procedure to follow in the event of an emergency and included current floor plans of the centre.

There was a personal emergency evacuation plan (PEEP) in place for each resident which included guidance for staff as to how to support each resident to evacuate in the event of an emergency. Where it had been identified that one of the residents might refuse to evacuate the premises in an emergency situation, there was and additional 'supporting unsafe behaviour plan'. However this issue had also been identified as a risk for another resident, but no supporting plan was available.

When staff members were asked by the inspector how they would proceed if residents refused to evacuate, staff each gave different responses that, whilst would ensure the safety of the resident, were not consistent. This inconsistently could lead to confusion in the event of an emergency and pose a risk to both residents and staff.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There was good practice for the most part in relation to the prescribing, dispensing and administration of medications. There was safe storage of medications, and detailed checks of delivery of medications.

Staff were in receipt of current training in the administration of medications, and their training included competency assessments. Staff were aware of the medications prescribed for each residents, and of the purpose of each in relation to the assessed needs of the resident.

There was a fairly new digital system of recording administration of medication, and while staff reported as finding the system effective and user friendly, some improvements were required to ensure oversight of administration, which was not being regularly checked. Failure to record the administration of a medication could be checked by looking through the individual records of each day and time of

administration, but this was not being undertaken. The inspector was concerned that medication errors, particularly where the medication was supplied in containers rather than blister packs would not be identified in a timely manner.

There was a system of checking the stock of loose medications that were supplied for PRN use whereby a weekly check was required. However, this was not consistently done, and of the record six weeks prior to the inspection reviewed by the inspector, this check had not been completed for two consecutive weeks on one occasion, and had been missed again on a later week. There was a discrepancy throughout the records for one of the medication which was explained by the staff member as being an error in documentation however, this was unclear, and had not been identified as an error. A recent medication audit had not identified the error.

However, a very detailed audit was undertaken annually by the supplying pharmacist, and this audit examined all areas of medication management.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There were personal plans in place for each resident, based on an assessment of need, and each was regularly reviewed. The assessments included information about each resident's preferences and abilities. The assessments were thorough and included information about all aspects of the required care and support needs of residents.

Sections in these personal plans included Personal and intimate care and eating, drinking and swallowing plans, and those reviewed by the inspector were detailed and provided clear guidance to staff.

In addition each resident had a person centred plan (PCP), which included goals in relation to maximising the potential of each resident. Goals were set in accordance with the preferences and abilities of residents, and included plans towards increasing opportunities and independence. For example, one of the residents was working towards having paid employment in the local community, and another was working towards increased travel opportunities.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required positive behaviour support, there were detailed plans in place, based on a detailed assessment of needs. The assessment of each resident included an assessment of healthcare needs and any potential impact on the

behaviours of concern for residents. For example, a resident who was prone to recurrent infections was known to have an increase in behaviours of concern if they had an infection, so this was closely monitored.

There was also detailed information about the presentation of each resident which might indicate signs of increased escalation, and the interventions that were required to ensure that the behaviours of concern did not further escalate. Staff members were all aware of these signs, and could describe the steps they would take to mitigate the risks and reduce the likelihood of any incidents of behaviours of concern.

Environmental adaptations had been made for some residents for example, there was reinforced glass in use in the environment for one of the residents, which reduced the requirement for restrictions such as physical holds if behaviours of concern occurred.

The records indicated that the consistent implementation of the guidance in behaviour support plans had significantly reduced the occurrence of behaviours of concern, which had led to improved outcomes for residents. This had also led to a significant reduction in restrictive interventions required to safely manage behaviours of concern.

However, improvements were required in the guidance for staff in relation to 'as required' (PRN) medication for some residents in relation to behaviours that challenge. Whilst there was some guidance as to when such medication should be administered, it lacked sufficient clarity to ensure consistent and effective administration. For example, one of the reactive strategies indicated that staff should 'give the residents space' prior to considering the administration of medication, but did not describe what this meant. The PRN protocol referred staff to the positive behaviour support plan, but this plan referred them back to the PRN protocol, with neither document giving precise guidance. In addition the records following the administration of PRN medication lacked sufficient detail as to review the effectiveness.

Judgment: Substantially compliant

Regulation 8: Protection

There was a clear safeguarding policy, and all staff were aware of the content of this policy, and knew their responsibilities in relation to safeguarding residents. Staff were in receipt of up-to-date training in safeguarding, and could discuss the learning from this training.

There were no current safeguarding issues or open safeguarding plans, however both the person in charge and the staff team were aware of their responsibilities in relation to the protection of vulnerable adults.

Judgment: Compliant

Regulation 9: Residents' rights

Staff had all received training in human rights and in assisted decision making, and gave examples of residents being supported in having their rights upheld. For example in their choice of activities and in making decisions about their daily lives. There had been recent improvements in the consultation with residents, both by residents' meetings and by individual conversations.

There was a clear emphasis in the centre of reducing any restrictive interventions as soon as it was safe to do so. One of the residents who was a fairly recent admission to the centre had already had restrictions removed or decreased, and as a result was accessing community facilities and events.

Judgment: Compliant

Regulation 6: Health care

Healthcare was well managed, and both long term conditions and changing needs were responded to appropriately. There were detailed healthcare plans in place, for example in relation to the risk of choking, and the management of epilepsy. The inspector observed the implementation of the guidance in these care plans in practice.

Residents had access to various members of the multi-disciplinary team (MDT) as required, for example the recommendations of speech and language therapist were included in the eating and drinking plan for residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 6: Health care	Compliant

Compliance Plan for Avalon OSV-0002433

Inspection ID: MON-0033460

Date of inspection: 30/01/2024

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Prior to the commencement of employment, the HR department will ensure that all staff have provided the information and documents outlined in schedule 2. • Additionally, the Person in Charge will conduct periodic annual audits of staff files using a comprehensive audit tool to verify the availability of all required documentation in accordance with Schedule 2.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • All staff commencing employment will complete day and night fire drills as part of the their induction to the centre. • At a minimum the Person in Charge will oversee biannual fire drills for all staff to ensure a thorough understanding of the evacuation procedures during emergencies. Insights from these drills will be shared with the team. • In cases where a resident may refuse to evacuate during an emergency, a supplementary support plan will be devised. If needed, a "supporting unsafe behaviour plan" will be established for emergency evacuations. These plans will be integrated into individual resident risk assessments and Personal Emergency Evacuation Plans (PEEP). • The PIC will ensure that all staff have thorough understanding of fire procedures. Discussions on fire procedures and PEEP understanding will be held during staff supervisions and monthly staff meetings. • Fire procedures will be regularly reviewed with residents during weekly meetings and prominently displayed in an easy-to-read format within the premises. • Staff will continue to undergo PMCB training and Positive Behaviour Support and Understanding Behaviour principles as part of their induction program and subsequently	

once every two years.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • The Person in Charge and staff nurses will undergo additional training in the use of the Digi Care system to ensure daily oversight of medication administration and to reduce the likelihood of medication errors. • This training will be extended to all staff involved in medication administration. • Weekly checks of loose medication stocks will be implemented to promptly identify any errors. The Talbot Group Medication Management Procedure Manual will be reviewed and updated to incorporate this practice. • PRN stock checks will be conducted according to current procedural guidelines. • The PIC will conduct thorough monthly medication audits, promptly addressing any discrepancies and sharing lessons learned with staff. • A Governance Assessment/Audit Tool for Regulation 29: Medicines and Pharmaceutical Services has been developed and is currently undergoing pilot testing. This tool will provide oversight at the Assistant Director of Service or Director of Service level, ensuring the robustness of monthly medication management audits conducted by the PIC.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • All residents' current PRN protocols will be reviewed by each residents prescribing clinician giving precise guidance on PRN administration. • The Behavior Support Team together with Directors of Services and Director of quality and safety have reviewed the inspector's feedback and will review the positive behavior support plans to ensure there is clarity and clear detail and guidelines for staff to follow. • The existing template for Individualized Psychotropic PRN Protocol protocols has undergone a thorough review and is now in its final draft stage. It will be finalized in alignment with the Positive Behaviour Support guidelines. • The Standard Operating Procedure (SOP) for PRN (PRO re nata) medications is in its final draft stage pending approval from the Senior Management Team. This SOP incorporates a comprehensive PRN effect template for the administration of PRN Psychotropic Medications. Its implementation will ensure that all residents receive appropriate support for behaviours of concern.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	19/03/2024
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.	Substantially Compliant	Yellow	19/03/2024
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	Substantially Compliant	Yellow	30/04/2024

	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.			
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	19/04/2024