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:	Sylvan Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	27 June 2023
Centre ID:	OSV-0001485
Fieldwork ID:	MON-0035251

About the designated centre

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

Sylvan Services provides both residential and respite services for up to nine male and female residents aged over 18 years with a diagnosis of intellectual disability. Residents have various degrees of support needs, ranging from minimum to high, which may include co-morbidity. Sylvan Services comprises two houses in residential settings on the outskirts of a city. The houses are centrally located and close to amenities such as shops, restaurants, public transport, pharmacists and churches. The houses are comfortably furnished, have gardens, and meet the needs of residents. All residents have their own bedrooms. Residents are supported by staff teams which include the person in charge, social care workers and care assistants. Staff are based in the centre whenever residents are present, including at night time.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 27 June 2023	09:30hrs to 17:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to follow up on non compliance's identified during the previous inspection of this centre, to assess the provider's compliance with specific regulations and also the regulatory compliance plan submitted to the Chief Inspector of Social Services on an organisational level.

The inspector met and spoke with staff members on duty, the person in charge and the assistant director of client services. The inspector also met with four residents.

Sylvan services comprises of two houses which are situated in residential areas close to a city. One of the houses is a single storey dwelling and at the time of inspection was accommodating two residents in individual bedrooms. The bedrooms were personalised and decorated in line with residents preferences. One of the bedrooms had an en suite shower room and an additional shower room was also provided. The house was well laid out and met the needs of the two residents living there. Residents also had access to individual living and kitchen spaces as well as a sensory room and large enclosed rear garden area. The garden had a large lawn area and a variety of flowers and plants. The house was furnished in a homely style, well maintained and visibly clean throughout.

During the afternoon, the inspector met with the two residents living in the house. Both residents had separate living spaces, one resident had their own living room and kitchenette and prepared their own snacks and cups of tea. While residents were unable to tell the inspector their views of the service, both seemed relaxed and content in their environment and in the company of staff. From a review of photographs, residents records and speaking with staff, it was evident that residents continued to enjoy participating in a number of activities in the local community. One resident attended regular day services during the week days. The other resident was supported with a day service from the house since the onset of the COVID-19 pandemic. This resident was assessed as requiring 2:1 staff support while out in the community, while staff advised that they tried to support the resident with a choice and range of activities including daily outings, they were of the opinion that this residents quality of life would be enhanced by attending an appropriate and suitable day service.

The second house was a dormer style two storey dwelling. There were four residents living in the centre, one resident was availing of a respite service. Staff informed the inspector that there were three service users who regularly availed of the respite service on a rotational basis. All residents were accommodated in single bedrooms which were personalised and decorated in line with residents' preferences. Residents had access to a variety of communal living spaces including a large sitting room, dining room and kitchen on the ground floor. There was also a second sitting room on the first floor. Residents had access to an enclosed paved garden area to the rear of the house and to a lawn garden area at the side of the house. The house was found to be generally well maintained and visibly clean

throughout. Issues identified at the last inspection including tiling of the kitchen walls, replacement of flooring to a ground floor bedroom, replacement of defective handrail to the ground floor shower room had been addressed. Further refurbishments required had been identified by staff including replacement of the sofas to the main living room, upgrading of the ground floor shower room and front entrance porch area. Staff advised that quotes for the new furniture had been submitted to head office and they were waiting on approval of same.

The inspector met with two residents during the afternoon on their return from day services. Another resident had gone home for the evening to spend time with family and the other resident had not yet returned from their day service. Residents spoken with stated that they were happy living in the centre and got on well with one another. They advised that they liked the house and their bedrooms. They were observed to be happy and content as they relaxed in the sitting room watching their preferred programmes on television. They told the inspector that they had decided to get a take away meal later in the evening and how they had enjoyed eating out at the weekend. They mentioned how they had recently painted the outdoor furniture and had planted a variety of colourful flowering summer plants in pots. They advised that they had been enjoying the recent warm weather and had eaten outside and had BBQ's. One resident told the inspector how they had enjoyed a recent birthday celebration in a local hotel and had stayed overnight. They showed photographs and videos of the party celebrations on their mobile phone which was attended by family, friends and staff members. They mentioned how they regularly enjoyed attending the cinema and were looking forward to going the following evening. They also mentioned enjoying a recent trip to a pet farm, attending regular yoga, music and dance sessions. Some residents liked to attend local church services. They mentioned how they were looking forward to going away for an overnight stay in a hotel and maybe attending a concert.

The inspector reviewed the minutes of weekly house meetings which showed that residents decided on and planned their preferred activities and weekly menu on a weekly basis. The weekly menu plan was displayed in pictorial format in the kitchen areas. Some residents enjoyed helping out with household tasks such as laundry, vacuuming, grocery shopping and meal preparation.

Residents were supported and encouraged to maintain connections with their friends and families. Visiting to the centre was being facilitated in line with national guidance and there were no restrictions in place.There was plenty of space for residents to meet with visitors in private if they wished. Residents regularly received visits from family members and also kept in contact by telephone. Some residents regularly visited and stayed at home over night with their family.

All residents had their own bedrooms and each resident had an individualised intimate care and support plan in place to ensure that their privacy and dignity was respected. Staff were very knowledgeable regarding the individual needs, likes, dislikes and interests of the residents. During the inspection, residents were observed enjoying the interaction and company of staff. There was a relaxed and friendly atmosphere in both houses. Staff were observed to interact with residents in a caring, courteous and respectful manner. Staff were observed spending time and

interacting warmly with residents, responding to and supporting their wishes.

Throughout the inspection, it was evident that staff prioritised the welfare of residents, and that they ensured residents were supported to live person-centred lives where their rights and choices were respected and promoted. Staff spoken with advised that staffing levels in the centre had stabilised over recent months and that there were now always two staff in each house during the morning, afternoon and evening time. A pictorial staff roster was displayed in each house so that residents knew what staff to expect on duty.

While improvements were noted to some of the governance and management arrangements and staffing, further improvements were still required. Further oversight was required in relation to individualised assessments and personal planning, to the review of incidents and risk management. These issues will be outlined further in the the next two sections of the report.

Capacity and capability

This designated centre is run by Ability West. Due to concerns in relation to Regulation 23: Governance and management, Regulation 15: Staffing, Regulation 14: Person in Charge, Regulation 5: Individualised assessment and personal plan, and Regulation 26: Risk management procedures, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in April 2023 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan the provider has outlined an action plan to the Chief Inspector highlighting the steps they will take to improve compliance in the registered centres. These regulations were reviewed in this inspection and this report will outline the findings found on inspection.

The findings from this inspection showed that the provider had implemented some improvements to the overall governance and management arrangements in the centre however, further improvements were still required in order to comply with Regulation 23.

The provider had implemented the compliance plan submitted following the last inspection.

There were now formal on-call management arrangements in place for out of hours, seven days a week. The details of the on-call arrangements were notified to staff on a weekly basis and clearly displayed in the centre. Staff spoken with were familiar with the arrangements in place.

The Chief Inspector had received notification of the planned absence of the person in charge from 27 March 2023 and the arrangements in place for the management of the centre in the absence of the person in charge. The Chief Inspector was recently notified of a new person in charge as of the 21 June 23. The inspector met with this person in charge on the day of inspection who advised that they were filling the role as an interim arrangement. They advised that a new person in charge had been recruited and was due to commence in the role in early July 2023 following the completion of induction training. A team leader had been appointed in December 2022 to assist the person in charge in the operational management of the centre. The team leader advised that they been allocated 12 hours per week to this administrative and operational role.

Staffing levels in the centre at the time of inspection were in line with the statement of purpose. While there were two social care workers on leave, both had been replaced by regular relief staff and a new person in charge was due to commence in the role in July. The staffing roster reviewed indicated that there were two staff on duty in each house during the mornings, afternoon and evenings. There was one staff on duty in each house at night time. The staff roster was completed up to the end of July 2023. Improvements were required to the staff roster to ensure that the full names, roles and hours worked were reflected in the roster. For example, it was not always clear what hours were worked when the roster indicated 'split shift'. The operational management hours allocated to the team leader were not reflected on the roster. The person in charge advised that a standardised staff roster was due to be implemented in all Ability West centres.

The team leader advised that training was provided to all staff on an on-going basis, records reviewed of regular staff showed that they had completed mandatory training. Additional training in various aspects of infection prevention and control, feeding, eating, drinking and swallowing, medication management, diabetes awareness and epilepsy care had also been provided. However, there were no training records available for relief staff. Further training was scheduled in risk management and respiratory emergency.

In line with the regulatory plan submitted by the provider, the person in charge and team leader confirmed attendance at a number of recent training workshops which had been arranged by the provider to support and enable persons in charge and team leaders in their roles. Training included roles and responsibilities, risk management, Flex maintenance system, quality enhancement plans and discussion on new templates, filing systems and assessments being implemented by the provider across all services. The team leader advised that they had recently completed a management training course.

The provider had some systems in place to monitor and review the quality and safety of care. The annual review for 2022 had been completed. Consultation with residents and their families as well as an overview of key areas of regulation had been used to inform this review. Unannounced audits were being carried out twice each year on behalf of the provider. The most recent provider led audit had been completed in March 2023 with a focus on Regulation 23: Governance and management and Regulation 26: Risk management. The audit had found both of

these areas to be non compliant. Actions as a result of these reviews had been set out in an action plan and had been addressed or were in progress of being addressed. For example, the risk register had been reviewed and updated for 2023. Regular reviews of identified risks, health and safety, medication management and restrictive practice were completed.

While the risk register had been updated and was being regularly reviewed on a monthly basis, further oversight and improvements were required. For example, staffing had been recently identified as one of the top five risks in the centre, however, staffing was not included in the centre risk register. The measures and actions in place to control this identified risk were not included in the register. Further oversight was also required to arrangements in place for investigation and learning from serious incidents. There was no evidence available that an incident reported to the Chief Inspector in September 2022 regarding an allegation of financial abuse relating to a resident had been fully investigated by the provider. The management of residents' finances had not been identified as a risk. Staff spoken with advised that the finance department had completed a financial audit but were not aware of the outcome of the audit, of any investigation and there had been no learning shared as a result of the incident. Staff working in one house had put a system in place whereby two staff members checked individual residents money balance sheets each morning and evening as an additional safeguard. However, there was no protocol in place to guide staff in these arrangements and it was not being implemented by staff in the other house.

Management systems in place had not ensured that the service was appropriate to the needs of all residents. There was one resident who was being provided with a day service from their house since the onset of the COVID-19 pandemic. Staff spoken with, meeting records, day service reports and consultant psychiatrist review indicated that the current day service from the house was not suitable to meeting the needs of this resident. This lack of an appropriate and suitable day service was impacting negatively upon the residents quality of life. There was no plan in place for an alternative day service at the time of inspection.

Improvements were required to ensuring effective oversight of assessments and personal planning documentation. This will be discussed further under the quality and safety section of this report.

Regulation 14: Persons in charge

The Chief Inspector was recently notified of a new person in charge on the 21 June 23, however, the prescribed documentation had not yet been submitted. This person in charge was filling the role as an interim arrangement. They advised that a new person in charge had been recruited and was due to commence in the role in early July 2023. The Chief Inspector has not yet received notification of this new appointment.

Judgment: Substantially compliant

Regulation 15: Staffing

Improvements were required to the staff roster to ensure that it was properly maintained. The full names, roles and hours worked by staff were not fully reflected in the roster. For example, it was not always clear what hours were worked when the roster indicated 'split shift'. The operational management hours allocated to the team leader were not reflected on the roster.

There were no training records available for relief staff who worked in the centre as required by schedule 2 of the regulations, and therefore, the inspector could not be assured that staff had completed mandatory and other appropriate training.

Judgment: Substantially compliant

Regulation 23: Governance and management

Further improvements were required to ensure that the service provided was safe, appropriate to the residents needs, consistent and effectively monitored.

Further oversight and improvements were required to risk management. For example, staffing had been recently identified as one of the top five risks in the centre, however, staffing was not included in the centre risk register. The measures and actions in place to control this identified risk were not included in the register.

Further oversight was required to arrangements in place for the investigation and learning from serious incidents. There was no evidence available that an incident reported to the Chief Inspector in September 2022 regarding an allegation of financial abuse relating to a resident had been fully investigated by the provider or that the management of residents' finances been identified as a risk with appropriate control measures in place.

Management systems in place had not ensured that the service was appropriate to the needs of all residents. There was one resident who was being provided with a day service from their house since the onset of the COVID-19 pandemic. Staff spoken with, meeting records, day service reports and consultant psychiatrist review indicated that the current day service from the house was not suitable to meeting the needs of this resident. This lack of an appropriate and suitable day service was impacting negatively upon the residents quality of life. There was no plan in place for an alternative day service at the time of inspection.

Improvements were required to ensuring effective oversight of assessments and

personal planning documentation.

Judgment: Not compliant

Quality and safety

The local management team and staff strived to ensure that residents received an individualised, safe and good quality service. However, further oversight and improvements were required to individual assessments of residents needs, personal planning documentation and ensuring that referrals to allied health services were acted upon.

The inspector reviewed a sample of residents' files. Residents needs had been recently assessed using a new standardised needs assessment template 'My support needs assessment'. The assessments had been carried out by the team leader and an assigned member of the multi-disciplinary team. A total numerical score had been calculated for each resident but staff, the team leader and person in charge were unable to interpret the score result. The person in charge advised that the completed assessments had been submitted to the senior management team and they were currently waiting on further guidance on how to interpret the scores. The assessments were not informative, they did not identify the type of supports required, actions required due to risk identified, staff skill set or staff training needs to support the needs of residents.

Further oversight was required in relation to residents files and personal planning documentation as many inconsistencies were noted. Some files reviewed showed evidence of regular review, however, some care plans including a swallow care plan and an end of life care plan had not been reviewed since 2020. There were draft behavioural support plans dated 2021 where the final review report had been requested but not been received. There was contradictory information provided in some documentation reviewed, for example, a residents intimate care plan contained information that was contrary to information and support needs outlined in a recent case review report. A referral to the occupational therapist for a seating assessment completed in November 2022 had not been responded to, despite a number of follow up emails requesting an assessment. There was no evidence that a referral to the physiotherapist dated March 2021 had been acted upon.

Personal plans had been developed in consultation with residents, family members and staff for full-time residential residents, however, there were no personal plans available for respite residents. The inspector was informed that personal plans for respite residents were overseen and records maintained by the day services. Review meetings took place annually, at which residents' personal goals and support needs for the coming year were discussed and documented. Individual goals were outlined along with the names of those responsible for supporting each resident achieve the goals in the plan within agreed timescales. However, it was difficult to assess

progress of the goals as there was no progress log maintained and no evidence of formal review meetings held to discuss progress or effectiveness of the plans.

There were systems in place for regular review of the risk register on a monthly basis. The inspector reviewed the risk register which had been recently updated in June 2023. The person in charge and team leader had recently completed a training workshop on risk management and training was planned for all staff in the coming months. The person in charge outlined the risk escalation pathways and confirmed that the top five centre risks are discussed at the monthly team meetings and with the director of operations on a regular basis. Improvements required to the oversight of risk management have been discussed under the capacity and capability section of this report.

Regulation 26: Risk management procedures

There were systems in place for regular review of the risk register on a monthly basis. The inspector reviewed the risk register which had been recently updated in June 2023. The person in charge and team leader had recently completed a training workshop on risk management and training was planned for all staff in the coming months. There was a clear risk escalation pathway in place and the local management team confirmed that the top five centre risks are discussed at the monthly team meetings and with the director of operations on a regular basis. Improvements required to the oversight of risk management have been included under Regulation: 23 Governance and management.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Improvements were required to ensure that a comprehensive assessment of health, personal and social care needs of each resident was carried out. Residents needs had been recently assessed using a new standardised needs assessment template 'My support needs assessment'. The assessments were not informative, they did not identify the type of supports required, the action required due to risk identified, the staff skill set or the staff training needs to support the needs of residents. Staff were unable to interpret the assessment score result.

Further oversight was required in relation to residents files and personal planning documentation as many inconsistencies were noted. Some care plans including a swallow care plan and an end of life care plan had not been reviewed since 2020. There was contradictory information provided in some documentation reviewed, for example, a residents intimate care plan contained information that was contrary to information and support needs outlined in a recent case review report.

Further oversight was required to ensure that referrals to allied health services were acted upon. A referral to the occupational therapist for a seating assessment completed in November 2022 had not been responded to, despite a number of follow up emails requesting an assessment. There was no evidence that a referral to the physiotherapist dated March 2021 had been acted upon. There were draft behavioural support plans dated 2021 where the final review report had been requested but not been received.

Improvements were required to personal planning to ensure residents were supported to achieve meaningful goals. There were no personal plans available for respite residents. While personal plans were in place for residents who availed of full-time residential placements, it was difficult to assess progress of the goals as there was no progress log maintained and no evidence of formal review meetings held to discuss progress or effectiveness of the plans.

Judgment: Not 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	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Sylvan Services OSV-0001485

Inspection ID: MON-0035251

Date of inspection: 27/06/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A Person in charge has been appointed to the position of Person in Charge of Sylvan Services and commenced in the role on 3rd July 2023. The current Person in charge continues to be in post until 24th July when the new person in charge will commence in their role and assume responsibility for the Sylvan Services. Induction for the new person in charge has been ongoing since 3rd July and this has been provided by the person participating in management. NF30A to confirm the appointment of the new person in charge will be completed on 24th July 2023 and all required paperwork will be submitted on 24th July 2023. The Induction for the new person in charge will continue until 30th August 2023 and will be supported and reviewed by the person participating in management	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Planned and actual Roster has been updated to include full names, roles and hours of work on the 28th June 2023. The person in charge is responsible for ensuring that there is adequate staff on the roster to the meets the needs of the residents in the Sylvan Services. The rota is reviewed on a weekly basis by the person in charge. Operational management hours for both the person in charge and the team leader are detailed on the roster. There is an induction file in place for relief staff who work in the Sylvan Services. The person in charge is responsible for ensuring that all relief staff complete induction in the service . Training records and training matrix for the relief staff is in place in Sylvan services since 28th June 2023.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The current person in charge completed a review of the risk assessment in relation to the staffing for the service and the centre risk assessment was updated in relation to	

this risk on 27 June 2023.

The Person Participating in Management will review the centre risk register and the top five risks on a monthly basis with the Person in charge and ensure that effective control measures are in place . If warranted the person in charge will escalate a risk to the Person Participating in management. Where a risk cannot be safely addressed within the service, the Person participating in management will escalate the risk to the Director of Operational Supports and Services will escalate the risk to the Corporate Risk Register via the Senior Management Team.

Risk management training was delivered by an external training organization to the current person in charge and the Team leader on 21st & 26th April.
Risk awareness training will be carried out with all staff in Sylvan services on 5th September.
Risk Management training will be carried out with the new person in charge on 28th July 2023
The person in charge will review the centre risk register on a monthly basis or more frequently where evidence of increased risk or other changes arises .

The Person in charge will review all incidents as and when they occur to identify trends, evidence or other indicators that a review of risk assessment is required.

Re the allegation of financial abuse, an investigation was carried out by the Designated Officer on 23rd September 2022. In addition a finance audit was carried out by a member of the Ability West finance team .Following the finance audit and investigation, additional controls and protocols regarding the management of resident finances were put in place immediately. The Protocols was further updated on the 30th June 2023 and was addressed at the scheduled staff meetings on 17th July and 19th July 2023, and will be addressed again at the August Staff meeting .Resident finances will be an agenda item at staff meetings going forward effective from July 2023.
The Person in Charge is responsible for ensuring resident finances are managed in compliance with the protocol and procedures.

Staff meetings are facilitated by the person in charge and at these staff meetings, standing agenda items will include review of incidents, risk register resident finance management and management and changing needs of residents.

Day service provision Review; The Day service Provision for the resident was last reviewed by the Case Management Team on the 19th June 2023 and a further review is scheduled for 27th and 28th July 2023. In the interim period, the Positive Behavior Team continue to work with the day service team to ensure the provision of a suitable day service for this resident . The key objective is to support the resident to return to day service as soon as possible .

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The current person in charge completed a review of the risk assessment in relation to the staffing for the service and the centre risk assessment was updated in relation to

this risk on 27 June 2023.

The Person Participating in Management will review the centre risk register and the top five risks on a monthly basis with the Person in charge and ensure that effective control measures are in place . If warranted the person in charge will escalate a risk to the Person Participating in management. Where a risk cannot be safely addressed within the service, the Person participating in management will escalate the risk to the Director of Operational Supports and Services will escalate the risk to the Corporate Risk Register via the Senior Management Team.

Risk management training was delivered by an external training organization to the current person in charge and the Team leader on 21st & 26th April.
Risk awareness training will be carried out with all staff in Sylvan services on 5th September.
Risk Management training will be carried out with the new person in charge on 28th July 2023.
The person in charge will review the centre risk register on a monthly basis or more frequently where evidence of increased risk or other changes arises .

The Person in charge will review all incidents as and when they occur to identify trends, evidence or other indicators that a review of risk assessment is required.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Needs assessments have been reviewed and updated for all residents in the Sylvan Services as at 20th July 2023.

The person in charge is responsible for ensuring that residents' assessments of needs are up to date and accurate. The Team leader has delegated responsibility to update residents' needs assessments at least monthly, or more frequently if it is evidenced that a resident's needs are changing. Team leaders will report to the person in charge in their weekly meetings to assure that this level of monitoring and updating of residents' needs is effective.
The person in charge has assigned keyworkers to each resident, with delegated responsibilities for supporting residents with their personal plans and support. The Team Leader and Person in Charge will guide and support keyworkers to ensure that support plans and Person-Centered Care Plans are reviewed and updated monthly or more frequently, as required.

My All About Me Assessment document is an existing Ability West document which is completed by the Person in Charge and the Keyworker, it can be located in the personal plans for the purpose of review.
The Person in Charge will ensure that this document is regularly reviewed when an emerging/ changing need is identified.

My Support Needs Assessment has been completed by the Team Lead/ Key workers and

a member from the MDT. This should remain on file in the personal plan. This document is stage one of a Provider needs assessment to inform current and future needs for each Resident in Ability West. This process was discussed at a workshop with all Managers on 26th June 2023.

PCP reviews are currently taking place within the Centre to ensure that the progress and effectiveness of personal plans for each Resident within the Centre are recorded with identified keyworkers supporting the Residents with their identified objectives. Formal meetings to review the effectiveness of personal goals have been scheduled to include all members of the Residents circle of support.

All outstanding referrals have been resubmitted to the Occupational Therapist, Behaviour support and Physiotherapist on 14th July 2023. The person in charge will continue to follow up on these referrals until they are closed out.

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(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.	Substantially Compliant	Yellow	24/07/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	28/06/2023
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the	Substantially Compliant	Yellow	28/06/2023

	information and documents specified in Schedule 2.			
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.	Substantially Compliant	Yellow	27/06/2023
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.	Substantially Compliant	Yellow	01/08/2023
Regulation 26(1)(d)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	31/08/2023

	policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	20/07/2023
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).	Not Compliant	Orange	20/07/2023
Regulation 05(6)(c)	The person in charge shall ensure that the	Not Compliant	Orange	20/07/2023

	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 effectiveness of the plan.			