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:	Oaklands Supported Accommodation
Name of provider:	The Rehab Group
Address of centre:	Longford
Type of inspection:	Short Notice Announced
Date of inspection:	10 February 2021
Centre ID:	OSV-0002668
Fieldwork ID:	MON-0031972

About the designated centre

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

Oaklands is a designated centre operated by Rehab Group which provides a residential service to people with a disability. The service is provided in a detached two storey house with a large landscaped garden with recreational area. There are four bedrooms and various communal areas including a sensory room. The house is situated in close proximity to the local town. The house is currently staffed on a twenty-four hour basis due to the impact of COVID-19. Generally the house is staffed between 15.00 hrs and 09.30hrs on week days as residents attend various activities. The provider undertakes to provide additional staffing as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 10 February 2021	10:30hrs to 16:30hrs	Eoin O'Byrne	Support

What residents told us and what inspectors observed

The inspector found that the centre was well maintained and designed and laid out in a homely manner. There were pictures of residents and staff members engaging in activities with one another throughout the centre. The centre had adequate space for residents to take time away, and residents had been supported to personalise their bedrooms. Residents were observed to appear comfortable in their surroundings. Residents relaxed in their rooms and the centres sitting room during the inspection.

Through observations and review of residents' information, the inspector found that residents were receiving care that promoted their independence, seeking to develop skills in areas such as communication and daily living skills. The inspector also reviewed questionnaires that residents had been supported to complete regarding the service they were receiving. The residents expressed that they were happy with the service. The inspector also observed warm and pleasant interactions between the residents and the staff members supporting them during the inspection.

A review of residents' information demonstrated that before restrictions imposed due to the current pandemic residents were engaged in activities in their communities, such as going for day trips, attending day service programs, being involved in local clubs, and also being supported to engage in education programs.

The current and previous restrictions imposed had impacted upon such opportunities. However, residents were being supported to partake in activities of their choosing where possible. A review of residents' daily notes identified that the staff team was seeking to promote residents' independence around daily living activities. Individualised day programs had been developed for residents and were being facilitated by members of the provider's day service staff that were familiar with the residents. One of the residents expressed that they were happy with this arrangement.

The inspector had the opportunity to meet with the two residents. One resident informed the inspector of their plans for the day through sign language. The staff member supporting the resident was knowledgeable of their non-verbal communication skills and supported the inspector to interact with the resident. There were visual aids (pictures of the residents preferred items and activities) and visual activity planners being utilised to support the resident. The inspector noted that the activity planner was utilised to support the resident in preparing for a planned activity and that this was successful in calming the resident.

The second resident spoke with the Inspector for a number of minutes. The resident spoke of liking where they lived and about some of their hobbies, including the football team they supported and other sports. The resident spoke of being supported by staff to engage in activities they enjoyed and informed the inspector that they were engaging in a fundraising activity. Residents were also being

supported to engage in positive risk-taking to further develop their rights and independence. There were appropriate risk assessments in place to support these opportunities.

The centre had not been in operation for a number of months during 2020. Residents and their family members had chosen for residents to return to their family homes in response to the COVID-19 pandemic. Two out of the three residents had returned to the centre in September 2020 and were supported to maintain strong connections with their families. A review of questionnaires regarding the service provided to residents demonstrated that residents representatives were happy with the service their loved ones were receiving. Some family members had raised possible improvements, and there was evidence of these suggestions being considered by the provider.

While there were systems in place to meet the needs of residents, there was a need to ensure that these systems were under regular review and being implemented effectively. The existing management arrangements were not ensuring this. As a result, there were a number of areas identified that were impacting the quality of service being provided to residents. These will be discussed in section two and three of the report.

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

The provider's capacity and capability to provide the highest standard of care and support was affected by inadequate governance and management arrangements.

The provider had ensured that there was a management structure in place, but the current management system was not effective in ensuring that all practices and information were effectively monitored. This, in turn, had resulted in improvements being required in a number of areas to ensure that residents were receiving the best possible service. The identified areas included protection against infection, management of complaints, risk management, providing information to residents regarding safeguarding, and ensuring that residents were supported to develop individual goals. The provider had not ensured that these areas had been appropriately monitored or implemented therefore impacting on the service being provided to the residents.

The centre was led by a person in charge who provided support and guidance remotely due to the COVID-19 pandemic. The person in charge was also responsible for a number of other services that were being delivered by the provider and had limited oversight of this centre. In the person in charges absence the centre's team leader was responsible for carrying out audits and monitoring of information

however, the team leader was completing shifts and was assigned a limited amount of time per week to carry out auditing practices. The inspector found that this arrangement was not effective; the lack of oversight had led to the provider not implementing appropriate risk controls in areas including infection prevention and control.

Furthermore, it was noted that some records and assessments were not easily accessible or were not the most up-to-date documents. The team leader informed the inspector that they had raised their concerns regarding limited monitoring to the person in charge and that this was under review. The inspector was also informed by the provider's senior management that a recruitment process was being prepared to recruit for a person in charge to solely work in the residential services.

The provider had, carried out the required reviews and reports on the quality and safety of care and support provided as per the regulations. The provider had carried out an annual review for 2020; this was completed in October 2020, and actions had been identified; however, a review of actions demonstrated that the provider had failed to capture all areas that required improvement and had not ensured that the service being provided was effectively monitored.

The provider did identify a number of actions following the annual review and the inspector notes that these actions were being addressed. The inspector also found that there were local audits being completed. The team leader had completed monthly audits, and the identified actions had been addressed or were being processed.

The inspector observed that there was easy read information regarding making a complaint and the procedure available for residents to review if required. One of the residents that the inspector spoke with also informed them that they could speak to staff if they had any concerns. Residents' family members were also aware of the complaints procedure. The inspector noted that a complaint had been raised in June 2020. The available documentation did not demonstrate that the complaint had been investigated promptly or any further details regarding how the complaint had been managed. The inspector was informed that the provider's senior management had been involved in the process, but there was no evidence available for review.

The provider had ensured that the number and skill mix of staff was appropriate to the number and assessed needs of the residents. A review of planned and actual rosters demonstrated that staff members were receiving continuity of care as there was a consistent staff team in place.

The inspector found that the provider had appropriate arrangements in place regarding staff training and development. Staff members had access to appropriate training; the provider had also provided resident and centre specific training to the staff team.

Overall, it was found that there was an absence of effective and responsive management systems to ensure that residents were receiving the best possible service. The oversight and auditing of practices being carried out in the centre

required review.

Regulation 15: Staffing

The provider had ensured that there was an appropriate compliment of staff to meet the needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

There were arrangements in place to ensure that the staff team could access training and refresher training when required.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that the current management systems were leading to the effective monitoring of the service being provided to the residents.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were improvements required to the providers documentation regarding the management of complaints.

Judgment: Substantially compliant

Quality and safety

While the inspector found that there were systems in place to promote the rights and independence of residents, the current management systems were impacting

upon the provider's ability to provide the best quality service to all residents. Issues were identified with the upkeep and auditing of documentation relating to infection prevention and control procedures, individual assessments, risk management, and safeguarding practices.

The provider had developed a number of risk assessments and a contingency plan in response to the COVID-19 pandemic. An appraisal of these documents found that there were improvements required to ensure that infection prevention and control procedures were appropriate. While the provider had developed an isolation plan that would be utilised if there were suspect or confirmed cases of COVID-19 amongst the residents, the plan outlined that a resident would not be capable of self-isolating and that a move to an isolation unit would not be appropriate due to the needs of the resident. There was no further information on how the staff team were to support this resident or the other residents living in the centre.

The provider was alerted to this by the inspector and asked to provide an updated isolation plan. This was submitted in the days following the inspection. The provider had called for an internal case review to be carried out regarding how best to support the resident and identified that there were increased behavioural supports required for the resident.

The provider had ensured that staff members had completed appropriate training in infection prevention and control, that there were enhanced cleaning practices in place, and that there were systems in place to ensure that staff members had access to sufficient personal protective equipment (PPE). The inspector observed that residents were being encouraged to wear surgical masks when interacting with others. The inspector does, however, note that one of the residents required regular prompting to ensure that their mask was being worn correctly.

The inspector found that the provider had developed a risk register that had recently been reviewed. Following a review of the risk register and observation of a resident's behaviour, the inspector noted that the provider had failed to adopt appropriate infection prevention and risk control measures to safeguard the residents and staff members supporting the residents. A resident was observed by the inspector to struggle to maintain social distancing and to also engage in behaviours that had the potential to put others at risk in regards to infection control. The inspector notes that this behaviour may have increased due to their presence in the centre as the resident can find unfamiliar people difficult to manage.

There was a risk assessment regarding the behaviour and behaviour support plan in place. However, neither of these captured the potential risk in regards to infection prevention and control. This was alerted to the provider, who was asked to provide assurances that measures would be introduced to address the concerns. The provider updated the risk assessment and guidance for staff. Staff members were observed to be wearing surgical masks when supporting the residents. The updated risk assessment stated that face shields were also required when supporting a resident to ensure that there were appropriate risk control measures in place.

There was a local safety statement that demonstrated that the provider had systems

in place for the investigation and learning from serious or adverse incidents. The inspector noted that there were no recent recordings of incidents. The provider had identified this in the annual review for 2020 and queried whether there was under reporting of incidents. This was discussed with the centre's team leader and senior management, who stated that this was under review; staff members were also due to complete incident management refresher training.

The provider had ensured that assessments of residents' health and social care needs had been carried out. The inspector reviewed a sample of the residents' information and found that aspects of the information were disorganised. Residents had been supported to develop individual goals for 2019; the inspector notes that for some residents that the process for developing these goals was detailed and person-centered. Goals had been developed for 2019, but there was no clear follow-up or evidence that the identified goals had been progressed or achieved. Furthermore, there was no documentation of personal goals being identified for 2020 or so far in 2021. While a review of daily notes demonstrated that residents were being supported to engage in activities of their choosing, there were improvements required to support residents to identify and achieve person-centred goals.

A review of the information presented to the inspector demonstrated that the provider had not ensured that residents were being supported to develop the knowledge, self-awareness, understanding, and skills needed for self-care and protection. On the day of the inspection, there was no easy read information available for residents on safeguarding or who the identified safeguarding officer was. The provider had,however, ensured that staff members had received appropriate training about safeguarding and that there were systems in place to respond to safeguarding concerns.

Residents were receiving appropriate healthcare. They had access to a range of allied healthcare professionals and were supported to attend medical appointments. The inspector reviewed a plan to prepare a resident for a medical procedure. The resident spoke with the inspector about the recent procedure and that they were recovering well.

There were visual aids and communication supports located throughout the house to support residents to express their needs and wishes. The inspector reviewed documentation regarding how these were to be utilised and the reasoning for their introduction. Residents were being supported by positive behavioural support specialists; a review of residents' information demonstrated that there was regular input regarding residents' behaviours and that the behaviour support plans that were reviewed were detailed and focused on identifying and alleviating the cause of the residents' behaviours.

Regulation 10: Communication

The provider had ensured that there were effective communication supports in place

for residents. The inspector observed supports being utilised and noted that resident had access to communication supports if required.

Judgment: Compliant

Regulation 17: Premises

The centre was well maintained and designed and laid out to meet the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had not ensured that all risks had been appropriately identified and that there were appropriate control measures in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had failed to devise an appropriate isolation plan to support residents and the staff team supporting them if an outbreak of COVID-19 was to occur.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were aspects of residents information that was disorganised and had not been reviewed for a long period. There were also improvements required in regard to ensuring that the supports required to maximise the residents' personal development were captured in their personal plans and person-centred plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate healthcare professionals

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that resident to access positive behaviour supports specialists.

Judgment: Compliant

Regulation 8: Protection

The provider had not ensured that residents were being supported to develop the knowledge, self-awareness, understanding, and skills needed for self-care and protection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had ensured that the rights of residents were being promoted and respected by those supporting them

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Oaklands Supported Accommodation OSV-0002668

Inspection ID: MON-0031972

Date of inspection: 10/02/2021

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. A new PIC is being actively recruited to specifically manage the Longford residential services. Unsuccessful recruitment campaign ran over December 2020 which led to a second recruitment campaign launched January 2021. Interviews scheduled for March 4th 2021 and March 5th 2021. Second round interviews scheduled for 16th March 2021.
2. The PIC is in contact daily to review and plan with the Team Leader what actions are required within agreed time frames, utilizing SMART goals. The team leader has been provided with increased admin hours from 12/02/2021 to support with local governance needs. These hours will be reviewed when the dedicated PIC is in post. Currently the PIC is conducting monthly audits whilst the team leader is conducting the weekly audits. These are then reviewed with the PIC, individual staff as required and via team meetings. As part of both weekly and monthly audits the requirement is to review support plans, person centered goals, daily practices and required documents, feedback is then provided to keyworker and shared to the team at Team Meetings. The outcomes of audits is a standing agenda item at all team meetings allowing for shared learning, discussion and action planning as required.
3. Supervision meetings have been increased with all staff, now being scheduled every 4 weeks. This will be reviewed following the appointment of the new PIC for Longford residential services. This will allow for actions, expected outcomes and achievements/challenges to be identified and ensure all are documented in line with the individual's needs and the company's framework. Schedule available onsite. PIC has also introduced a monthly Keyworker checklist 11/02/2021 to ensure compliance across keyworker duties.
4. Team meetings have been increased to 2 meetings per month from 16/02/2021 ensuring the team have time to discuss any achievements, concerns, challenges etc with the PIC and to facilitate local roll out of Training including BT input. This ensures there is full and complete communication among the team. This will be reviewed following the appointment of PIC for the Longford residential services. The BT is scheduled to attend

team meetings scheduled in March 2021, then ongoing support will be upon PIC request. The service is using the team meeting agenda within RehabCare framework for residential services. Behaviour Support plans are reviewed within the team meetings under Keyworker updates.
5. Staff are proactively implementing the company's documentation framework to ensure all documents can be sourced when requested. PIC will review as part of Monthly audit. To ensure the framework is embedded within the service it is a standing team meeting agenda item. The service is working towards a deadline of 31st March 2021 to have the framework embedded.
6. All risk assessments have been reviewed and updated by the PIC following a covid case management meeting held on the 16th February 2021 with senior management and the Chief Risk Officer. These have been shared, discussed and implemented with the team. Team meeting held 25th February 2021. Covid Contingency plan updated 10/02/2021.
7. PIC has further reviewed the Safe Guarding and Trust in Care policy and procedures with the team on the 25th February 2021. Staff have further reviewed the social stories, posters and visuals in situ with the service users to support understanding. House meeting was held 01/03/2021 with residents. Safeguarding was discussed and minuted. House meetings are held weekly, the PIC has drafted a schedule of items for discussion including Safeguarding, making a complaint, local finance policies, charter of rights etc. Each item will be discussed at a minimum every 6 months as part of the house meetings. All residents participate in the house meetings. PIC made contact with the RehabCare Advocacy Officer Claire Gibson 08/03/2021 to schedule a meeting with residents.
8. PIC and BT delivered an Incident reporting and management refresher session to the team on 25/02/2021. PIC explained the RIVO system and highlighted the reporting procedure to PIC, ISM and BT. PIC and ISM have oversight of all incidents recorded and are required to be closed off by PIC. BT also issue guidelines re incidents of behaviours of concern 25/02/2021.
9. PIC has ensured the full detail of complaints resolved are on the file for reference, PIC has discussed the importance of printing and filing the same with the team. Completed February 25th 2021
All compliance actions will continue be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. The complaints file has been updated in line with the company's documentation

framework. Completed 22nd February 2021.
2. PIC has ensured the full detail of complaints resolved are on the file for reference, PIC has discussed the importance of printing and filing the same with the team. Completed February 25th 2021.Complaints and compliments continue to be an agenda item for team meetings. Completed 25th February 2021.
3. The team continue to support the service users understanding of this policy and procedure via visual aids and social stories during key worker sessions and service user meetings. Staff document the same for reference.
4. All compliance actions will continue be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. All risk assessments have been reviewed and updated by the PIC following a Covid case management meeting on the 16th February 2021 with senior management, behaviour therapist and the Chief Risk Officer. These have been shared, discussed and implemented with the team. Completed 16th February 2021. Covid Contingency plan updated 10/02/2021.
2. Case Management will continue to be used as required, PIC will continue to ensure staff are updated regarding the same.
3. Risk assessments will continue to be an agenda item for team meetings. Completed 25th February 2021. Standing item on agenda.
4. PIC and BT delivered an Incident reporting and management refresher session to the team on 25/02/2021. PIC explained the RIVO system and highlighted the reporting procedure to PIC, ISM and BT. PIC and ISM have oversight of all incidents recorded and are required to be closed off by PIC. BT also issue guidelines re incidents of behaviours of concern 25/02/2021.
5. All compliance actions will continue be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. All risk assessments have been reviewed and updated by the PIC following a Covid case management meeting on the 16th February 2021 with senior management, behaviour therapist and the Chief Risk Officer. These have been shared, discussed and implemented with the team. Completed 16th February 2021. Covid Contingency plan updated 10/02/2021.
2. Case Management will continue to be used as required, PIC will continue to ensure staff are updated regarding the same
3. Infection Prevention Control will continue to be an agenda item for team meetings. Completed 25th February 2021. Standing item on agenda.
4. All compliance actions will continue be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

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:
1. The PIC is in contact daily to review and plan with the Team Leader what actions are required within agreed time frames, utilizing SMART goals. The team leader has been provided with increased admin hours from 12/02/2021 to support with local governance needs. These hours will be reviewed when the dedicated PIC is in post. Currently the PIC is conducting monthly audits whilst the team leader is conducting the weekly audits. Within the audits both the PIC and TL review all PCP and goals set and will monitor goal completion through Iplanit. Audit findings are then discussed with individual staff as required and via team meetings. As part of both weekly and monthly audits the requirement is to also review support plans, feedback is then provided to keyworker and shared to the team at Team Meetings. Audits is a standing agenda item at all team meetings. Coaching for staff for PCP goal setting within Covid restrictions is being rolled out 11/03/2021 by PIC to support residents to identify and achieve person centered goals.

2. Supervision meetings have been increased with all staff, now being scheduled every 4 weeks. This will be reviewed following the appointment of the new PIC for Longford residential services. This will allow for actions, expected outcomes and achievements/challenges to be identified and ensure all are documented in line with the individual's needs and the company's framework. Schedule available onsite. PIC has also introduced a monthly Keyworker checklist 11/02/2021 to ensure compliance across keyworker duties.
3. Team meetings have been increased to 2 meetings per month from 16/02/2021 ensuring the team have time to discuss any achievements, concerns, challenges etc with the PIC and to facilitate local roll out of Training including BT input. This ensures there is full and complete communication among the team. This will be reviewed following the appointment of PIC Longford. The BT is scheduled to attend team meetings scheduled in March 2021, then ongoing support will be upon PIC request. The service is using the team meeting agenda within RehabCare framework for residential services. Behaviour Support plans are reviewed within the Team meetings under the Keyworker section any changes are presented here.
4. Staff are proactively implementing the company's documentation framework to ensure all documents can be sourced when requested. PIC will review as part of Monthly audit. To ensure the Framework is embedded within the service it is a standing team meeting agenda item. The service are working towards a deadline of 31st March 2021 to have the framework embedded.
5. All compliance actions will continue be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. PIC has further reviewed the Safe Guarding, Trust in Care policy and procedures with the team on the 25th February 2021. Staff have further reviewed the social stories, posters and visuals in situ with the service users to support understanding. House meeting was held 01/03/2021 with residents. Safeguarding was discussed and minuted. House meetings are held weekly, the PIC has drafted a schedule of items for discussion including Safeguarding, making a complaint, local finance policies, charter of rights etc. Each item will be discussed at a minimum every 6 months as part of the house meetings. All residents participate in the house meetings. PIC made contact with RehabCare Advocacy Officer Claire Gibson 08/03/2021 to schedule a meeting with residents.
2. PIC and BT delivered an Incident reporting and management refresher session to the team on 25/02/2021. PIC explained the RIVO system and highlighted the reporting procedure to PIC, ISM and BT. PIC and ISM have oversight of all incidents recorded and

are required to be closed off by PIC. BT also issue guidelines re incidents of behaviours of concern 25/02/2021.
3. All compliance actions will continue be validated utilizing the organizational SharePoint validation system. This system holds all actions from both internal and external inspections and allows for on-going monitoring, tracking and validation of actions being completed at service level. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager. This system is utilized at Regional and National level to monitor compliance by the Senior Management and the Quality and Governance Directorate.

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 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	31/05/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	16/02/2021
Regulation 27	The registered provider shall ensure that residents who may	Not Compliant	Orange	16/02/2021

	be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	16/02/2021
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	07/03/2021
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and	Substantially Compliant	Yellow	01/03/2021

	protection.			