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:	St Rita's Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	06 February 2025
Centre ID:	OSV-0003915
Fieldwork ID:	MON-0043803

About the designated centre

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

St Rita's Residential Service can support four male and female adults, with intellectual disability and or autism as well as additional physical and or sensory disability. Residents supported at the service range in age from 18 years upwards. The centre comprises of a purpose built house in a rural town. Residents are supported by a staff team that includes the person in charge, social care workers and social care assistants. Staff are based in the centre when residents are present, including at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 6 February 2025	11:15hrs to 17:00hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to review the actions that had been taken by the provider following the previous inspection of this centre on 13 March 2024. At that time, three regulations were found to be not compliant. The provider submitted a compliance plan outlining the actions that would be taken to address the issues identified on inspection. On this inspection, it was found that not all actions had been implemented by the provider and that areas of non-compliance remained. In some cases, there had been no improvement in relation to significant issues that had been identified by the inspector previously; for example, restrictive practices and auditing of the service. In addition, further areas requiring significant service improvement were identified by the inspector. Significant improvement was required in relation to the use of restrictive practices, risk management systems, communication supports, staff training, and the promotion of the resident's human rights. The governance and oversight systems in the centre required significant improvement in order to evaluate and drive service improvement in the centre.

The centre consisted of a large, single-storey building in the middle of a town. It was close to shops, cafes, hotels and other local amenities. A large garden was located at the back of the house. Each resident had their own bedroom. Three bedrooms had en-suite bathrooms. The fourth bedroom had direct access to the main bathroom in the centre. One bedroom was fitted with a tracking hoist in the ceiling that extended into the en-suite. The main bathroom also had a tracking hoist.

Since the last inspection of this centre, the provider had undertaken a significant project to refurbish a section of the building to meet the needs of residents. The provider refurbished one resident's bedroom and their en-suite bathroom. This increased the space within the rooms and made them more accessible for the resident. The provider had also renovated a hallway and store room to provide a living room and kitchenette for the resident. The newly renovated section of the building was very tastefully decorated. It had new furniture consisting of three armchairs and a small dining table. There was a television in the resident's bedroom. The living room also had a large television. The kitchenette was equipped with a kettle, fridge and sink. As a result of this refurbishment project, the resident was now able to use their own en-suite bathroom rather than the shared main bathroom. The living room was available to the resident to spend time alone, when they wanted. Staff reported that the resident had gone to furniture shops to choose the furniture for their new bedroom and living room.

The inspector noted that some of the cupboard doors in the new kitchenette were locked. One locked cupboard contained food. The other locked cupboard contained the kettle, plates and glassware. The cupboard under the sink was not locked. This contained a bin. Staff retained the keys for the locked cupboards. The person in charge reported that the cupboards were locked due to risks to the resident. This

will be discussed later in the report.

The inspector met with all four residents at different times throughout the day. The inspector greeted the residents and spent some time with them in the centre. One resident showed the inspector their bedroom and the new living space in the centre. Residents spent time in the centre or on outings with the support of staff. Residents communicated through non-linguistic means.

In addition to the person in charge, the inspector met with two other staff members. Staff were knowledgeable on the residents' preferences. They spoke about the supports that they provided to residents in relation to their daily care and when going into the community. Staff spoke about the recent renovations in the centre and the positive impact that it had on the residents' lives. Staff were heard chatting with residents. Staff welcomed residents when they returned to the centre and provided support to residents throughout the day.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes how governance and management impact the quality and safety of the service provided.

Capacity and capability

Improvement was required to governance and oversight procedures to ensure that the service delivered was of a high-quality, suited to the needs of residents, and that it protected and promoted their rights. Issues identified on the previous inspection of this centre in relation to audit and ensuring that audit findings were addressed were again noted on this inspection. Any actions taken by the provider in the intervening months had not been effective at improving the oversight of the service. Audits were not all completed in line with the provider's schedule. Where issues were identified, the system used to address these findings and record their progress was not adequate. This meant that some actions were not addressed or it was unclear if they had been addressed. The provider-led audits completed in this centre had not identified issues that were noted by the inspector. In addition, the provider had not submitted all notifications to the Chief Inspector of Social Services as required by the regulations.

The staffing arrangements in the centre were suited to the needs of residents. The number and skill-mix of staff on duty were adequate to support residents with their daily activities. Though a vacancy existed in the centre, this had been filled by regular staff and the person in charge. Staff were familiar to the residents. New members of staff had commenced working in the centre in recent weeks and months. One new staff member was undergoing induction on the day of inspection. However, staff training required significant improvement. Staff training records indicated that in some areas 50% of staff required refresher training.

Regulation 15: Staffing

Staffing arrangements were suited to meet the needs of the residents.

The inspector reviewed the rosters in the centre from 30 December 2024 to 02 March 2025. These indicated that the required number of staff were available to support residents at all times. There was one staff vacancy in the centre at the time of the inspection. The person in charge reported that a process to fill this post had been commenced. The person in charge and the centre's manager were required to fill this vacant role on occasion. This was recorded on the centre's roster. The staff were consistent and familiar to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Improvement was required in relation to staff training in the centre.

The training records that were available in the centre were reviewed by the inspector. These indicated that not all staff had up-to-date training in all modules and in some areas, 50% of staff required refresher training. For example, the records in the centre indicated that eight of 16 staff required training in managing behaviour that is challenging. In addition, eight of 16 staff required refresher training in medication management.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector was not assured that the provider maintained adequate oversight of the quality and safety of the service delivered to residents in this centre.

There were clear lines of accountability and defined management structures in this centre. Incidents were reviewed and analysed to identify any trends. However, significant improvement was required in relation to the oversight of the service.

During the previous inspection of this centre on 13 March 2024, this regulation was found to be substantially compliant. The provider's compliance plan at that time outlined that all issues in relation to this regulation would be addressed by 30 June 2024. On the current inspection, a number of issues had not been addressed by the

provider, as outlined below.

The inspector reviewed the audits that had been completed in the designated centre in the year prior to the inspection and noted the following:

- Some audits were not completed in line with the provider's schedule. For example, the financial audits were due to be completed monthly. However, records indicated that these audits were completed sporadically. The most recent financial audit had been completed in October 2024. During the previous inspection of this centre, it was also found that audits were not completed in line with the provider's schedule. Through their compliance plan, the provider had committed to introduce a checklist to ensure that all audits were completed in time. This action was not effective.
- The quality of information obtained from audits did not always identify areas for service improvement. For example, all monthly medication audits completed in 2024 indicated that staff required training in 'COVID-19'. However, it was not clear why this training was required and, if so, it was not clear if this training had been delivered. Again, this was a finding on the previous inspection of this centre and had not been effectively addressed by the provider in line with the timeline stated in their compliance plan.
- Where areas for service improvement were identified, it was not always clear if they had been addressed. The audits did not record what actions should be taken, who was responsible for the actions, and when they would be completed. As a result, it was not always clear that actions had been addressed. The person in charge reported that an informal process was in place. Actions were deemed to be complete if they did not reoccur on subsequent audits. However, this system did not adequately drive or monitor service improvement. Through the compliance plan from the centre's previous inspection, the provider had committed to the introduction of a SMART action plan to address audit findings. This had not yet been introduced in the centre on the day of this inspection. Again, this was outside of the provider's target completion timeline of 30 June 2024.
- Not all actions identified on audit were addressed. As outlined under regulation 10: communication, audit findings for one resident that were identified in April 2024 had not been addressed on the day of inspection.
- Provider-led audits were not completed in line with regulations and did not identify areas requiring significant improvement. The provider had completed the most recent six-monthly unannounced audit on 13 December 2024. The last provider-led unannounced audit prior to that had been completed on 24 April 2024. This was outside of the six-monthly timeline specified in the regulations. In addition, the audit completed in December 2024 had failed to identify a number of issues that were noted by the inspector. For example, the most recent audit noted that the analysis of restrictive practices was comprehensive. However, the inspector found that significant improvement was required in this area, as outlined under regulation 7: positive behavioural support.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had not notified the Chief Inspector of all restrictive practices in the centre, as required by the regulations. The most recent quarterly notification to the Chief Inspector did not include information about the use of locked cabinets in the new kitchenette.

Judgment: Not compliant

Quality and safety

The previous inspection of this centre in March 2024 found areas of non-compliance that negatively impacted on the quality and safety of the service in the centre. While the issue relating to one resident's living space had been addressed appropriately by the provider, issues remained in relation to restrictive practices and the promotion of residents' rights.

The provider had undertaken a significant project that had resulted in a new living space and remodelled bedroom for one resident. This positively impacted on the resident's daily life as they now had more space to spend time alone and could use their en-suite bathroom.

The quality of the service was negatively impacted by the provider's failure to protect the rights of residents. The introduction of the new living space had not resulted in a reduction of the restrictions placed on residents, particularly in relation to their access to their bedrooms after meals. The provider did not have systems that were adequate to evaluate, review and reduce the use of restrictive practices. Reviews had not been completed with the input of the human rights committee or members of the multidisciplinary team. This had resulted in practices that significantly impacted the rights of residents remaining in effect for extended periods of time. The restrictive practice records and risk assessments did not always justify their use. Adequate information was not available to guide staff on how to support residents to make choices in relation to their daily lives.

Regulation 10: Communication

The residents in this centre required significant support with their communication and used non-linguistic means to communicate. The provider did not ensure that all residents were supported to communicate their needs and wishes. In addition, the

provider did not ensure that staff were aware of residents' communication supports.

The inspector reviewed the communication profiles for two residents. It was noted that these profiles were generic and did not provide details of the residents' specific communication strategies. In addition, the communication profiles were not signed or dated. Therefore, it was unknown who had completed the profiles and if they were still relevant. This had been identified by the provider in relation to one of the residents. It was recorded on an audit of the resident's file that had been completed in April 2024. However, on the day of inspection, this had not been addressed.

In addition, residents had not been referred to a speech and language therapist for support in relation to their communication, despite documented changes to recommendations that had been made by a speech and language therapist in the past. For example, one resident had been assessed by a speech and language therapist in 2019 who had advised the use of objects to support the resident's communication. An audit of the resident's file in April 2024 found that some of the objects were no longer relevant to the resident. However, on the day of inspection, a referral had not been made to speech and language therapy to review the resident in light of their changed communication needs.

Judgment: Not compliant

Regulation 17: Premises

As outlined in the first section of the report, the centre was suited to the needs of residents. The provider had undertaken a significant renovation project in October 2024. This had resulted in a more spacious bedroom and en-suite bathroom for one resident. A store room and hallway had been converted into a second sitting room with kitchenette and dining table. This ensured that all bedrooms were of a suitable size and suited to the needs of residents. Residents had adequate space to spend time together or alone, if they wished. The centre was well maintained. It was clean and in a good state of repair.

Judgment: Compliant

Regulation 26: Risk management procedures

Significant improvement was required in relation to the risk management arrangements in the centre. This regulation was found to be not compliant in the previous inspection of the centre on 13 March 2024. The actions taken by the provider in the intervening period had not been effective to ensure that the risk management systems were adequate to identify, reduce and review risks to the

residents.

The inspector reviewed the risk assessments for two residents and found a number of issues that required improvement:

- The risk assessments in the residents' files were not up-to-date. Both residents' risk assessments had not been reviewed in line with the provider's timeline of every three months. One resident's risk assessments were last reviewed in March 2024 and the other in August 2024. As a result, assurances could not be provided that the risks were still relevant or that the control measures were adequate to reduce the risks.
- Risk assessments were not always reflective of the risk to residents. For example, one resident had an orange-rated risk assessment related to pica. Numerous restrictive control measures had been introduced to reduce the risk and, in the previous 12 months, only one minor incident had occurred. This high level of risk rating was not reflective of the situation in the centre and may have resulted in overly restrictive control measures that impacted the rights of the resident.
- All control measures were not implemented in the centre in line with the risk assessments. For example, one risk assessment advised that bins should be kept in locked cupboards due to a resident's risk of pica. However, the inspector noted that the bin in the kitchenette was kept in an unlocked cupboard.
- Risk assessments had not been reviewed in light of the new layout and facilities within the centre.

Judgment: Not compliant

Regulation 7: Positive behavioural support

On the previous inspection of this centre on 13 March 2024, this regulation was found to be not compliant. This remained the case on the current inspection. Significant improvement was required in relation to the use and review of restrictive practices in the centre.

The inspector reviewed the restrictive practice logs and records for two residents. These outlined the restrictive practices identified for each resident, the justification for their use, and the steps that should be taken by staff when implementing the restrictive practices. There was also a record of the dates and times when the restrictions were implemented. The inspector also spoke to staff and the person in charge in relation to these practices.

A number of issues were identified:

- Restrictive practices were not adequately reviewed in this centre. It was not clear that the least restrictive practice was in use for the shortest duration of

time. Though the restrictive practice log was signed to indicate that the restrictive practices had been reviewed by the person in charge on a three-monthly basis, there was no record of what this review entailed. Some restrictive practices had been in use in the centre for an extended period of time without adequate review. For example, the practice of locking residents' bedroom doors for 30 minutes after meals was decided at a multidisciplinary team meeting in 2017. This was referenced as the justification for its continued daily use. There was no evidence that this practice had been reviewed by the multidisciplinary team since that time. Through their compliance plan from the previous inspection, the provider had committed that the provider's human rights committee would review the restrictive practices in the centre. On the current inspection, the person in charge reported that restrictive practices in the centre had not been reviewed by the provider's human rights committee.

- There were a number of restrictive practices introduced in the centre in recent months that had not been identified, recorded or assessed. The new kitchenette, which was installed in the centre in October 2024, had numerous locked cabinets. Staff held the keys to these cabinets. This was not recorded on the centre's restrictive practice log. The impact on the resident had not been assessed. A risk assessment to justify the restrictive practice had not been completed. As a result, it was not clear if this practice was warranted and there was no guidance for staff on when or how to implement this practice.
- The continued use of long-standing restrictive practices and the introduction of new restrictive practices had been done without the guidance of relevant professionals. For example, staff reported that the cabinets in the kitchenette were locked to ensure that the resident did not access foods and appliances without supervision. However, referrals had not been made to behaviour support services or other members of the multidisciplinary team to assess if this practice was necessary or appropriate. There was also no engagement with relevant professionals to plan how the use of restrictive practices could be reduced by supporting residents to manage their behaviour.
- The restrictive practice log and risk assessments did not always provide clear justification for the use of restrictive practices or clear guidance to staff. For example, one resident was checked by staff every few hours at night. However, the reason for these checks was not recorded. Therefore, it was not clear what staff were checking for.
- The staff training records that were available for review indicated that eight of 16 staff required refresher training in supporting residents with behaviour management.
- Risk assessments relating to restrictive practice had not been updated to reflect the changes that had been made to the centre in recent months.
- The provider' audits had failed to identify the above issues, as outlined under regulation 23: governance and management.

Judgment: Not compliant

Regulation 8: Protection

The provider had systems in place to ensure that residents were protected from abuse. Staff had largely up-to-date training in safeguarding. In conversation with the inspector, staff demonstrated that they were knowledgeable of the processes that should be followed should any incidents occur. Incidents in the centre were recorded and reviewed regularly. There were no open safeguarding plans in the centre on the day of inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Significant improvement was required to ensure that the rights of residents were upheld and that they were supported to make choices in their daily lives.

- This regulation was found to be not compliant on the previous inspection of this centre on 13 March 2024. The provider's compliance plan at that time indicated that all staff would receive training in human rights-based care by 30 May 2024. On the day of inspection, it was unclear if this training had occurred. Human-rights training had not been included in the centre's training records and staff who spoke with the inspector said that they had not received training in this area.
- Systems had not been developed to ensure that residents were offered choices in relation to their daily activities and their care. As outlined under regulation 10: communication, resident's communication needs and supports were not clearly defined. Therefore, guidance was not available to staff on how to offer choices to residents and how the residents expressed their preferences. For example, the person in charge reported that residents were not given opportunities to make choices about their daily meals. The weekly menu was decided by staff based on the known preferences of residents.
- Residents were not always consulted or included in decisions about their lives. For example, the inspector reviewed two of the residents' files. These files contained a document called 'What's important to me?' This document outlined the resident's preferences and priorities. The document asked the residents' opinions on numerous matters including their living arrangements and personal goals. The person in charge reported that this had been completed by each resident's key staff member based on their knowledge of the resident. However, the residents had not been supported to be included in the development of this document.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Rita's Residential Service OSV-0003915

Inspection ID: MON-0043803

Date of inspection: 06/02/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The provider has implemented a new function on their learning management system which facilitates live updates on current training levels to the person in charge. This is in place since 19.03.2025 All staff requiring training are enrolled for the relevant upcoming event on the organization's training management system. The PIC has met with each staff member and agreed a date for this training to be completed at the next two learning events which will be completed by 16.05.2025. The person in Charge will complete a training needs analysis to reflect current training levels in the service. 07.04.2025	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Audits: The provider will complete the following audits in the center before 28.03.2025: -Medication -finance -Health and Safety	

-IPC
-IP
-Staff files
-Quarterly incident
-Data Protection audit

The provider will meet with the Person in charge and PPIM to share the outcome and actions required from all audits -03.04.2025

The PPIM/Provider will complete audits with the PIC on a monthly basis ,commencing on 28.05.2025 for a six-month period after which this arrangement will be reviewed. 20.09.2025

The provider will carry out an additional provider's focused unannounced visit in the service by the 18.04.2025 with a particular focus on the actions identified in this compliance plan.

The Provider has implemented 6 weekly business meetings between area managers and PIC's with a term of reference and a standard template. The first of these meetings occurred on 12.02.2025 with the next scheduled for 02.04.2025.

The PPIM will provide updates to the provider at 6 weekly intervals as part of a schedule of meetings arranged for the rest of 2025.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Provider will complete a review of all incidents and notifications to HIQA within the centre from March 2024 to present. As a result of this review any previously omitted notifications will be submitted to HIQA as per regulation. This will be complete by 28.03.2025

The PPIM will review all notifications pre submission for the remainder of 2025.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
The provider and the external Speech and language therapist will facilitate a review with the team of all communication profiles to ensure that they are person centered and reflect each person's will and preference in their preferred communication style. This will be complete before 20.04.2025

The provider has engaged an external Speech and Language therapist with knowledge of the residents to carry out a review of all communication profiles. This will be complete before 20.04.2025

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The provider will support the person in charge to review all residents risk assessments and the risk register in the service to ensure they are reflective of the current risks to residents and any corresponding restrictive practice is the least restrictive for the least amount of time. This will be completed by 16.04.2025

The provider will ensure the two members of the rights review committee will visit the service to review all rights checklists for residents in St Rita's, this is on the agenda for discussion with the full committee on the 16.04.2025.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC has begun a process of review of restrictive practices with a multidisciplinary team and the organizations rights review committee. All rights checklists will be updated with all current restrictions to be reviewed at a screening meeting of the Rights Review Committee on 19.03.2025.

The provider will ensure the two members of the rights review committee will visit the service to review all rights checklists for residents in St Rita's, this is on the agenda for discussion with the full committee on the 16.04.2025.

All staff requiring training in managing behaviors of concern are enrolled for upcoming events on the organization's training management system. The PIC has met with each staff member and agreed a date for this training to be completed at the next two learning events. Four staff will complete this training on 28.03.2025. The remaining staff will attend the event scheduled for 02.04.2025. The PPIM will review the training levels at the agreed 6 weekly business meetings with the PIC, The first of these meetings is scheduled for 02.04.2025.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: All staff in the center have completed human rights-based training between the dates of 22.04.2024 to the 18.09.2024.

The provider and the external Speech and language therapist will facilitate a review with the team of all communication profiles to ensure that they are person centered and reflect each person's will and preference in their preferred communication style. 20.04.2025

The provider has engaged with an external Speech and Language therapist with knowledge of the residents to carry out a review of all communication profiles to ensure that they are person centered and reflect each person's will and preference in their preferred communication style. 20.04.2025

A system for recording how residents are offered choices and accept or decline will be agreed with the staff team and implemented in the service and available for review.

The PIC has begun a process of review of restrictive practices with a multidisciplinary team and the organizations rights review committee. All rights checklists will be updated with all current restrictions to be reviewed at a screening meeting of the Rights Review Committee on 19.03.2025.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	20/04/2025
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	20/04/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional	Not Compliant	Orange	16/05/2025

	development programme.			
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	20/09/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	16/04/2025
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or	Not Compliant	Orange	28/03/2025

	environmental restraint was used.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	16/05/2025
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.	Not Compliant	Orange	16/04/2025
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	16/04/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates	Not Compliant	Orange	16/04/2025

	intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	20/04/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	20/04/2025
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	20/04/2025