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:	The Abbey
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Announced
Date of inspection:	16 January 2024
Centre ID:	OSV-0004761
Fieldwork ID:	MON-0033769

About the designated centre

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

The centre comprises of three separate houses. Currently, a residential service is provided from two of the three houses. The third house is not in use due to improvement works required. An individualised service is provided for one resident over the age of 18 years in each house. Both houses are located in residential areas of a large town and transport is provided for each resident to access their local community. Each resident has access to all of the facilities offered in a residential type setting and share their home only with the staff on duty. Residents are assessed as requiring a higher level of support from staff and there are always staff on duty. Staffing levels and arrangements differ in each house based on the assessed needs of each resident. The residents are offered an integrated model of care where both day and residential supports are provided in their home. The day to day management of the centre is delegated to the person in charge supported by a social care worker in each house.

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 (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 16 January 2024	10:15hrs to 18:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

The provider had applied to the Chief Inspector seeking renewal of the registration of this centre. This inspection was undertaken to inform that decision making process.

The inspector found that the provider had largely addressed matters that had arisen on previous inspections of this service. For example, one resident was well settled into their new home and this had addressed risks that arose to their safety due to the unsuitability of their previous home. This relocation had also resulted in a reduced level of environmental restrictions.

Overall, the provider demonstrated a good level of compliance with the regulations. There was good evidence that each resident was supported to enjoy the best possible health and a good quality life. However, the action that issued from the last HIQA (Health Information and Quality Authority) inspection in relation to positive behaviour support was not resolved. The inspector also found confusion in relation to the management structure of the centre. While this did not appear to impact on the level of compliance achieved, the lack of clarity as to each person's role and responsibilities in the management structure posed an inherent risk to governance and regulatory responsibilities.

On arrival at the first house the inspector was advised that the resident had, the previous evening, been unexpectedly transferred to the acute hospital services for review and treatment. The inspector therefore had the opportunity to meet with one of the two residents living in this centre. Each resident had their own home where they were supported by their team of staff. Each house largely operated independently of the other. For example, there was a social care worker in each house to support the person in charge and, different teams of staff.

The inspector had the opportunity to meet the person in charge, both social care workers and frontline staff in both houses. Staff spoken with had good knowledge of residents' needs, routines and support plans and, arrangements such as the procedures for evacuating residents. Staff had completed training in promoting a human rights based approach to care and spoke with the inspector as to how this was reflected in their practice. For example, both residents were not verbal communicators. Staff described how residents were offered choice and communicated, perhaps by gesture, their preferences. A staff member could clearly describe how a resident communicated if they wanted to leave to house or not for a family visit and said that while refusal was very infrequent the resident's choice was always respected. Staff had also completed a HIQA questionnaire on behalf of both residents and the feedback provided on behalf of each resident was positive and reflected the practice observed by the inspector. For example, the use of visuals to offer choice, regular community and family access.

Both residents had regular contact with home and family. For one resident this was

facilitated on a daily basis. The management and staff teams were in regular contact with both families. One family had provided feedback to inform the last annual service review (for 2022) and this feedback, which was on file, was very positive and rated the service provided as excellent. The provider also listened to any concerns raised and had procedures such as its complaint management procedures for responding to these concerns.

There were good arrangements in place for monitoring resident health and wellbeing. Some of these healthcare needs were complex with staff and family working together to support the resident.

The resident met with welcomed the inspector to their home with a warm smile and a range of physical interactions and gestures. This included picking up a specific soft-toy and handing it to the inspector. The resident was unperturbed by the presence of the inspector in their home and smiled when the inspector asked if it was for okay for staff to show the inspector the resident's bedroom.

The inspector noted the general maintenance and upkeep that had been completed in the house since the last HIQA inspection. For example, with input from the MDT (multi-disciplinary team) the resident's sensory room had been reinstated. New fencing had been erected to the rear of the property with robust supports to support a hammock for the resident. The inspector noted when visiting both houses the friendly interaction of neighbours and the good relationships developed with them.

In summary, based on what the inspector observed, read and discussed this was a good person centred service. The provider had progressed the plans submitted to HIQA and had improved the quality and safety of the service provided to residents. The standard of care and practice observed was good and the resident met with presented as content in their home and with the staff members on duty.

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

Capacity and capability

Overall, the findings from this inspection reflected a well-managed service. Governance and management was focused on providing each resident with a safe, quality service and a good quality of life. Incrementally, the provider had completed the actions it said it would to improve the quality and safety of the service and to improve its level of compliance with the regulations. The centre presented as adequately resourced. In general, while there was scope for improvement, the provider was monitoring and collecting data about the quality and safety of the

service.

The management structure at the time of this inspection was comprised of the person in charge supported by a social care worker in each house. The person in charge while recently returned to the role was very familiar with the needs of each resident and the general management and oversight of the service. Both social care workers understood their role and readily answered any queries raised by the inspector.

Systems of oversight included reviews such as of accidents and incidents, of medicines management, financial procedures, the annual service review and, the service reviews required by the regulations to be completed at least on a six-monthly basis. Overall, these internal reviews found much good practice and corrective actions where needed were progressed. For example, putting in place arrangements that better assured the safety of medicines management practice and altering daily routines so they were better suited to the sensory needs of a resident in response to incidents that had occurred.

However, the inspector did find in records seen and on speaking with staff that there was confusion and a lack of clarity as to who was the person in charge of the designated centre.

The staffing levels and arrangements in both houses were suited to the assessed needs of the residents and good provision was made for ensuring that staff had access to and attended appropriate training.

Regulation 14: Persons in charge

The person in charge had the required experience, skills and qualifications for the role. The person in charge was a member of the senior management team with other responsibilities but they were satisfied they had the capacity to effectively fulfill the role of person in charge. The person in charge was familiar with the service and the staff team and had good knowledge of each resident and their required care and support.

Judgment: Compliant

Regulation 15: Staffing

The staff duty rota was well presented and showed each staff member employed and the hours that they worked. The rota demonstrated that residents received continuity of care from a staff team familiar with their needs. Staffing levels and arrangements were suited to the assessed needs of each resident. There was flexibility in the staffing arrangements. For example, on the day of this inspection an

additional staff member was allocated to best support a clinical appointment for one resident. Nursing advice and care was provided by community and hospital based services.

The inspector requested a representative sample of staff files to review. The four files reviewed by the inspector were well presented and were fully compliant with the requirements of the regulations. For example, each file contained evidence of Garda vetting and re-vetting, job descriptions and, suitable evidence of each staff members identity.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the staff training records in one of the two houses. These records demonstrated that these staff had completed a broad range of training that included mandatory and required training and, additional training to support good practice. For example, staff had completed training in safeguarding, fire safety, responding to behaviour that challenged and, medicines management. Additional training included training on supported decision-making, applying a human rights based approach to care and, human rights based report writing. Management confirmed that formal staff supervisions were completed. The inspector saw that staff had access to the Act and regulations and other information issued by HIQA.

Judgment: Compliant

Regulation 21: Records

Any of the records requested by the inspector were available to review. For example, the assessment of each residents needs and their personal plan, inspection reports, details of the meals provided and, a record of the number, type and maintenance record of fire-fighting equipment.

Judgment: Compliant

Regulation 22: Insurance

The provider had documentary evidence that it had insurance in place such as insurance against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found in records seen and on speaking with staff members inaccuracy and confusion as to who was the person in charge of the designated centre. The governance and management structure recorded and discussed was not as set out in the statement of purpose and function for the centre. For example, the annual review while completed by the then person in charge stated another person was the person in charge. Staff in discussion with the inspector described how they had met with and discussed matters with the person in charge but this was not the person in charge of the centre. Where records seen stated that the person in charge had participated in for example, a personal planning meeting and a review of restrictive practices this was not the person in charge. There was an inherent risk in this confusion to effective and safe governance and, to regulatory roles, responsibilities and reporting relationships. In accordance with the requirements of the Act, the person in charge is the person whose name is notified to the Chief Inspector and entered in the register of designated centres maintained by the Chief Inspector and no other person.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had policy and procedures for the management of any complaints received. A record was maintained of the matters complained of, their investigation and, whether or not the complainant was satisfied with the response to their complaint. However, the inspector noted the scope of measures required for improvement was limited somewhat by the investigation that was completed. The reference to the possible use of a restrictive procedure as raised by the complainant was not adequately explored. This will be discussed again in the next section of this report.

Judgment: Compliant

Quality and safety

This was a person centred service where the support and care provided was individualised to the needs of each resident. The provider had largely satisfactorily progressed the actions it said it would to improve the quality and safety of the

service provided to residents. For example, staff reported that a resident was well settled into and enjoying their new home. In general, the support and care observed and described by staff spoken with was of a good standard and supported by input from the multi-disciplinary team (MDT). However, more input was needed to ensure that a resident had adequate and appropriate positive behavioural support.

Since the last HIQA inspection the personal plan had been updated to the providers personal outcomes measures (POMS) format. The inspector reviewed aspects of both residents personal plans. The plans set out each resident's needs and abilities and the support needed to promote the best possible outcomes for residents. It was evident from the plans and discussions with staff that resident health and wellbeing was consistently monitored and the care and support provided was informed by input from for example, the general practitioner (GP), psychiatry, speech and language therapy (SLT) and, hospital based clinicians.

The personal plan included the plan for responding to any behaviours of concern. However, while the plan was dated as reviewed in January-February 2023, the plan did still not address all types of behavior that were exhibited, the purpose of these behaviours and how they should be supported.

Overall, residents experienced very few restrictions and the reliance on environmental restrictions was reduced with the move to the new house. However, there was a missed opportunity in the investigation of a complaint to discuss and explore with staff the possible use of other restrictions that were not included in the personal plan.

There were systems for reviewing incidents and risk. The review of risk assessments and controls was linked to any incidents that occurred. There was evidence of corrective actions taken to reduce the risk of a reoccurrence. For example, a resident went to the supermarket during times more suited to their sensory needs and, a modification was made to one service vehicle following an accident and injury sustained by a resident. However, there was an over reliance on general risks and general controls to manage risks rather than risk assessments and controls that were more specific to the needs of the resident.

There were good arrangements in place for maintaining oversight of fire safety.

Regulation 10: Communication

Both residents communicated by means other than verbal communication. There were arrangements in place to support this. Based on the inspectors discussions with staff this was an area of support that it was hoped to develop further. For example,with the introduction of objects of reference. The inspector saw evidence of supportive communication tools such as a visual daily routine, meal planner, staff duty rota, a visual personal plan, the use of social stories, and a range of new sensory items. Staff spoken with could readily describe to the inspector how residents communicated by gesture or behaviour their needs and choices in

response to these tools.

Judgment: Compliant

Regulation 11: Visits

Residents had good access to home and family and could receive visits from family and peers in their house. There were agreed reasonable controls to ensure that visits in the designated centre and outside of the designated centre could be safely accommodated.

Judgment: Compliant

Regulation 13: General welfare and development

The daily routines in each house were individualised to the needs, abilities and personal circumstances of each resident. While there was scope for further improvement, the care and support provided was informed by input from the MDT. Physical health needs were not a barrier to a resident enjoying community access and a range of amenities with staff support. The other resident, also with the support of staff, enjoyed a range of community based activities such as swimming, horse-riding, visiting a sensory library, going for walks with staff, visiting peers or receiving visits from peers. Both residents had good opportunity to remain connected with home and family.

Judgment: Compliant

Regulation 17: Premises

Both residents were provided with a safe and comfortable home. The design and layout of these homes was suited to their needs and any associated risks. For example, one resident had relocated in early 2023 to a purpose built ground floor property and was reported by staff to have settled in very well to their new home.The provider had undertaken a programme of repairs and redecoration in the other house and it presented as bright and welcoming. The inspector saw that equipment suited to the assessed needs of residents was provided such as a profiling bed, handrails and grab-rails. Additional storage had been provided in one house but a further review of the storage provided for cleaning equipment was needed. This is addressed below when discussing the identification and

management of risks.

Judgment: Compliant

Regulation 18: Food and nutrition

Staff described how residents were supported to participate in the purchase of groceries and snacks. Staff described how residents were offered a choice of meals. Staff maintained a record of the meals and snacks provided to residents. The records indicated good variety and consideration of other needs and recommendations such as from the dietitian and SLT.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems for reviewing incidents and risks. However, there was an over reliance on general risks and general controls to manage risks that were specific to the needs of a resident. For example, recent falls experienced by the resident were referenced in the general slip, trips and falls risk assessment but the resident did not have a falls risk assessment peculiar to and individualised to them. The risk assessment for behaviour that challenged was not complete given the need for further input and additional guidance and controls. These gaps did not provide robust assurance that all of the controls needed were in place.

There was a risk assessment in place for manual handling. A specified control was the safe and appropriate storage of regularly used items so as to prevent an injury to staff. However, the mop buckets were stored in a very compact space under the stairs and access to this space posed a possible risk of injury to staff due to bending or kneeling on the floor to retrieve the buckets. The limited space also posed a risk to infection prevention and control as the full range of colour coded equipment as set out in the providers own policies and procedures could not be stored.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Both occupied houses were fitted with emergency lighting, a fire detection and alarm system, fire-fighting equipment and, doors designed to contain fire and its products: the doors were fitted with self-closing devices. There was documentary

evidence that these fire safety arrangements were inspected and tested at the appropriate intervals. Staff members in both houses confirmed that they participated in regular simulated evacuation drills with residents and said that both residents responded well to the evacuation procedure. This was evident from the drill records seen by the inspector. Staff described how the evacuation procedure for one resident had been reviewed and amended and said there had been no incidents of the resident going back into the house since these changes were made. The residents PEEP (personal emergency evacuation plan) outlined the revised evacuation procedure.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were arrangements in place that supported safe medicines management practice. For example, all staff had completed medicines management training including the administration of emergency medicines. The prescription was legible and staff maintained a record of each medicine they administered to residents. Staff administered medicines following an assessment of capacity and risk. There were procedures for the receipt of medicines from the pharmacist and the verified return of any unused medicines to the pharmacy. Incidents were recorded and investigated and corrective actions such as more frequent checks of stock balances were taken to better assure practice.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The personal plan had been transferred to the revised personal outcomes measures format (POMS) implemented by the provider. There was evidence that as appropriate to the needs and circumstances of each resident, representatives were consulted with and participated in the development and review of the personal plan. The plan was available to a resident in a format that was accessible and meaningful to them and provided good evidence of how the residents general welfare and development needs were met. MDT input had been sought and provided since the last HIQA inspection and the impact of this was evident. For example, in the refurbishment of the sensory room and the range of sensory items available. Staff spoken with confirmed that the resident did engage in their sensory programme with prompting and encouragement from the staff team.

Judgment: Compliant

Regulation 6: Health care

The personal plan included the plan for supporting residents' healthcare needs. Staff maintained a record of their monitoring of resident health and wellbeing and the actions they took when they had a concern. For example, staff contacted and sought support as needed from the on-call manager. A record was maintained of all referrals, advice given and, the care provided and recommended such as from the resident's general practitioner (gp), psychiatry, speech and language therapy (SLT), clinical nurse specialists and hospital based services. Monitoring records seen by the inspector confirmed the staff team implemented recommendations such as protocols for the administration of as needed medicines and regular monitoring of resident body weight.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behavioural support plan was dated as reviewed in January-February 2023. However, the inspector saw that the plan still did not address the management of behaviour that could be exhibited by a resident towards others including the inspector. These behaviours while gentle, posed a risk to good and dignified community access and integration for the resident. A staff member spoken with, as at the time of the last inspection, discussed the challenge for staff of the unpredictability of these behaviours. For example, the staff member discussed an incident that had occurred in a community based amenity and feedback that had been received about the incident.

There was a reduced reliance on environmental restrictions. However, there was a missed opportunity during the review of a complaint to explore and establish the circumstances of the possible use of other restrictions in the provision of care such as during venepuncture procedures.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had safeguarding policies and procedures. All staff had completed a blended programme of safeguarding training where they completed on-line and face-to-face training. The details of the designated safeguarding officer were prominently displayed in both houses. Staff used a range of accessible materials with residents as they sought to develop resident understanding of self-care and protection. There were recognised limitations to this in the context of each residents

disability. Staff used safeguarding tools such as body maps to record any injuries noted and each resident had a plan setting out their personal and intimate care needs.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that respected the needs and personal circumstances of each resident. Staff spoken with described how they consulted with and offered residents choice and control in their daily choices and routines. This was also reflected in records seen where staff recorded how residents were offered a choice of meals and of personal clothing. Staff could describe how residents expressed their choices and preferences such as readily getting their coat when they were happy to leave the house or, turning away from staff when they were not. Staff spoken with were very open to reviewing their own practice and working to continually improve resident independence, choice and control .

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Abbey OSV-0004761

Inspection ID: MON-0033769

Date of inspection: 16/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The service provider will ensure the following actions are taken to achieve compliance with Regulation 23: Governance and Management: • The Person in charge will review records held in the designated center and ensure the Person in charge is clearly outlined. In the event there is a coordinator with delegated responsibility for the day to day management of the center, this arrangement will be clearly outlined and the appropriate person will sign off on relevant documentation. [Planned completion: 28/02/2024]	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The registered provider will ensure the following actions are completed to ensure compliance with Regulation 26: Risk Management: • The person in charge will develop a Risk Assessment specifically related to the individual's falls and ensure all control measures are individualised. [Completed] • A falls management plan will also be developed for the individual and reviewed as necessary. [Planned Completion: 28/02/2024] • The risk assessment specific to Behaviors that challenge will be reviewed to include all behaviors exhibited by the individual and specific PBS strategies listed as the control	

measures. [Planned completion 31/03/2024]
• The Manual handling Risk Assessment will be reviewed and alternative storage for the mop buckets will be identified to ensure the Infection Prevention and Control measures are implemented as per policy. [Planned completion 31/03/2024]

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The service provider will ensure the following actions are taken to achieve compliance with Regulation 7: Positive Behavioral Support
• A comprehensive review will take place with the Positive Behavior Support therapist to ensure that all behaviors which may present as a challenge and impact on the experiences of the individual while interacting with others are addressed and strategies in place to support the individual. [Planned completion: 31/03/2024]
• The PIC will review the past complaint and address the possible unplanned use of a restriction and ensure that appropriate systems are in place to support the individual with future venepuncture procedures. [Planned Completion: 15/03/2024]

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)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	28/02/2024
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	31/03/2024
Regulation 07(1)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	31/03/2024

	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.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	15/03/2024