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 Willows
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	13 February 2020
Centre ID:	OSV-0003385
Fieldwork ID:	MON-0028644

About the designated centre

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

The Willows provides care and support for individuals with an intellectual disability, autism and individuals with a mental health diagnosis. 24-hour care is provided for four adults both male and female from 21 years of age. The centre is located in Co. Kildare and consists of two buildings. Residents have access to a number of vehicles to support them to access their local community. In the centre each resident has their own bedroom some of which are ensuite. There are a number of communal areas and access to kitchen and dining facilities. There are a number of enclosed rear gardens for recreational use. The aim of the centre is to provide a high quality standard of care in a safe, homely and comfortable environment for individuals with a range of disabilities. Support aims to be consistent with the mission, vision and values of the organisation and the centres' specific statement of purpose and function. Residents are supported by a person in charge/team leader, social care workers and assistant social care workers. Should additional staff be required, staffing numbers will be reviewed and amended in line with residents' dependencies. All residents undergo a full pre admission assessment, which includes an impact assessment of the new resident on existing residents. Residents are regularly reviewed and supported by a multidisciplinary team. Where the needs of the resident can no longer be met in the centre, this is identified by the person in charge, staff and multidisciplinary team, and the residents are supported to transition to alternative services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Thursday 13 February 2020	09:30hrs to 17:30hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

The inspector of social services had the opportunity to meet and spend some time with three of the five residents living in the centre during the inspection. The inspector did not get the opportunity to meet two of the residents as both times they visited their home, residents were out taking part in activities of their choice in the local community.

Throughout the day, residents were observed coming and going with the support of staff in the centre's vehicles to engage in activities in the local community such as walks to their favourite places, attending a local weight loss group, attending appointments with allied health professionals and shopping trips.

The inspector got the opportunity to briefly speak with one resident who was spending time with staff cleaning one of the centre's cars. They described how much they enjoyed this activity and explained that the reason they were cleaning it was in preparation to go to a valentines event later that day. They stated that they were looking forward to this event.

Another resident showed the inspector around their home including a tour of their bedroom where they showed the inspector things that were important to them. They sat with the inspector a number of times during the day to discuss what it was like to live in the centre and what they enjoyed doing every day. They described things they liked to do and things they had to look forward to. They discussed how they liked to spend their time including long walks, going to matches, fishing and talking with their family. They described the importance of staff support in taking part in activities and reaching their goals. They stated that they felt happy and safe in their home and that they were happy with the choices they were making daily. They described their involvement in the day-to-day running of their home including cleaning and choosing meals for certain days of each week.

The inspector also got to briefly meet one resident prior to them going off for the day to visit their family. They were excited about the upcoming trip and described their plans for the day. They told the inspector that they were happy living in this centre and described things they liked doing. They describe the support offered by staff in the centre to support them to do the things that they liked to do.

During the inspection, the inspector observed warm, kind and caring interactions between residents and staff. Residents were observed having chats with staff, completing arts and crafts and playing card games.

One resident described one area for improvement in relation to accessing the Internet in the bedroom. They discussed this with staff during the inspection and staff explained to the resident that they were in the process of looking into ways to improve Internet access in their room and would update this resident

regularly to let them know of any progress.

Residents' views in relation to the quality and safety of care in the centre were also captured as part of the annual review completed by the provider. In this review, the feedback from residents and their representatives were mostly positive. The review indicated that residents were satisfied with the meal choices, their rights and choices, with the support they were receiving to set and achieve their goals, with the levels of community engagement and with the complaints process in the centre. This review also indicated that residents' representatives were satisfied with the care and support for residents in the centre.

Capacity and capability

There were systems in place to monitor the quality and safety of care and support for residents in the centre. The provider was completing an annual review, 6 monthly visits and other audits in the centre. These reviews and audits were identifying areas for improvement and the management team were putting plans in place to complete the required actions to bring about these improvements.

The inspection was facilitated by the person in charge, director of operations (DOO) and deputy team leaders in the centre. They were all found to be knowledgeable in relation to residents likes, dislikes and preferences and motivated to ensure they were living an active and fulfilled life. They were meeting regularly and reviewing the systems in place to ensure they were effectively monitoring the quality of care and support for residents.

There were clearly defined management structures and systems to monitor the quality of care and support for residents in the centre. The person in charge was completing weekly and monthly reports and sending these to the DOO. The findings from these reports were shared with the executive management team and actions developed as required. There was evidence that actions identified in these reports and reviews were being followed up on and completed in line with the timeframes identified by the provider. There was also evidence that these actions were positively impacting on the quality of residents' care and support.

Staff meetings were occurring regularly. In response to the delay in concerns being raised to the management team by staff, the frequency of staff meetings had increased and a number of items had been added to the standing agenda for staff supervisions. These included; discussions in relation to the organisation's escalation policy, notifications to the Chief Inspector and safeguarding policies and procedures. The agenda items for staff meetings were found to be resident focused and there was evidence that incidents were reviewed and learning shared amongst the team at these meetings. In addition to staff meetings there was a process in place for staff handover at the end of each shift. There was a template in place to ensure relevant topics were covered during handover including safeguarding and incident review. At shift handover, staff were assigned specific duties and areas of

responsibilities for each shift. For example, it was clearly identified which staff were supporting residents both at home and during activities in their local community and the shift lead was identified at handover.

In line with the providers application to increase the footprint of the designated centre late in 2019 by adding new building providing living accommodation for two residents, they had employed additional staff to meet the increased number and needs of residents in the centre and to ensure residents were supported to transition into the centre. These staff had completed induction training and were in receipt of support and supervision from the management team while they were settling into their new roles and getting to know residents' likes, dislikes and preferences. In line with the increased number of staff now working in the centre, the provider had put interim measures in place to increase the availability of members of the management team. These measures included the addition of a deputy team leader and an increase in the frequency of staff meetings in the centre. From reviewing rosters in the centre, it was evident that residents were in receipt of continuity of care. A small number of shifts were being covered by regular relief staff. There was also evidence that a member of the local management team was on duty daily where possible. In addition, there was an escalation policy which detailed on-call support for staff. Staff who spoke with the inspector were aware of this escalation policy and clear in relation to their responsibilities to escalate any concerns relating to residents care and support.

Staff were in receipt of training and refreshers in line with the organisation's policies and residents' assessed needs. New staff had completed a comprehensive induction training prior to commencing work in the centre. There were systems in place in the organisation to ensure staff were alerted that they needed to complete training or refreshers. The person in charge also had systems in place to ensure staff had up-to-date training as required. Staff were in receipt of regular formal supervision which was being completed by members of the local management team. In response to a number of allegations of staff misconduct in the months preceding the inspection, a number of key topics were now being discussed as part of the standing agenda for supervision sessions. Staff who spoke with the inspector were knowledgeable in relation to residents' care and support needs and their responsibilities in relation to ensuring they were safe and in receipt of a good quality service.

Residents were protected by the policies, procedures and practices relating to admissions in the centre. Each resident had a comprehensive assessment of need completed prior to being admitted to the centre. In addition, impact assessments were completed to ensure that each resident in the centre was protected as part of the admissions process. Residents and their representatives had an opportunity to visit the centre prior to their transition. Contracts of care were in place for each residents and they contained information in relation to the support, care and welfare for residents in the centre and information relating to the services provided and fees to be charged. However, the inspector reviewed a number of contracts which required review to ensure they were reflective of the arrangements in place for these residents in relation to fees.

There were complaints policies and procedures available and on display in the

centre. These were discussed with residents at residents' meetings and during keyworker sessions. There was a local complaints officer identified and systems in place to ensure that complaints were recorded, investigated and followed up on. There was one open complaint in the centre and evidence that follow ups had been completed in response to this complaint. Records were maintained in relation to correspondence with the complainant and where possible complaints were left open until such time that the complaint could be resolved to the satisfaction of the complainant.

Regulation 15: Staffing

There were enough staff to meet the number and needs of residents in the centre. There were planned and actual rosters in place and evidence of continuity of care for residents. The provider had recognised the need to increase the number of deputy team leaders in the centre in line with the increase in the size of the staff team.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of training and refreshers in line with the organisation's policies and they had completed training in line with residents' assessed needs. Staff were in receipt of regular formal supervision to support them to carry out their roles and responsibilities to the best of their abilities.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures and systems in place to monitor the quality and safety of care and support for residents in the centre. These included the annual review and six monthly reviews by the provider and regular audits and meetings of the management team in the centre. Arrangements were in place to support and performance manage staff.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Residents were protected by the admissions policies, procedures and practices in the centre. Comprehensive needs assessments and impact assessments were completed prior to residents admissions to the centre. Residents and their representatives had opportunities to visit the centre prior to admission. Each resident had a contract of care in place which detailed the support, care and welfare to be provided for residents in the centre. However, a number of contacts reviewed required review to ensure they were reflective of the arrangements in place for residents in relation to fees.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was in place and available in the centre. It contained the information required by the regulations and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were complaints policies and procedures in the centre. They were available and on display in an accessible format. Records of complaints were maintained and there was evidence that complaints were followed up on and actions put in place to resolve complaints. The satisfaction level of the complainant was also recorded as part of the complaints process.

Judgment: Compliant

Quality and safety

Overall, residents were in receipt of a good quality and safe service. They lived in a comfortable home and were being supported to keep busy and spend time engaging in activities they enjoyed. There was evidence of positive risk taking and evidence that residents were trying different activities to see if they enjoyed them. Residents' independence was being encouraged and they were being supported to make

choices in relation to their day-to-day lives. They were involved in the day-to-day running of their home and supported to identify areas for improvement in relation to their care and support. There were gaps identified across a number of documents reviewed during the inspection but these were not leading to any immediate risk for residents as staff were aware of residents' care and support needs. The provider was identifying some of these gaps in their own reviews and audits and had plans in place to carry out the necessary actions to ensure documentation was reviewed to ensure it was reflective of residents' care and support needs and clearly guiding staff to support them.

The premises was warm, comfortable and well maintained. Residents were involved in decorating their bedrooms and in the maintenance and upkeep of their home. One resident told the inspector they loved living in the centre and another told them that they were happier in this centre than they had been in others. There was space for residents to spend time together or alone as there were a number of communal and private spaces available to them. The provider had identified the need to make further improvements to the gardens in the centre and described plans to make these improvements once the weather improved. In addition, plans were in place to install new gates at the front of the property. In the interim, the provider had risk assessments in place to manage the risks associated with this.

There was a residents guide which was available for residents in the centre. It contained the information required by the regulations and had been reviewed in line with the timeframe identified in the regulations.

One resident had transitioned from the centre since the last inspection and two residents had transitioned into the centre. The inspector reviewed records and spoke to staff and it was evident that the residents discharge was completed in a planned and safe manner in line with their wishes to move. They had a transition plan in place which was detailed in nature and there was evidence that the transition was completed at a pace suitable to them. Transition plans were in place for the two residents who had just transitioned to the centre. They were detailed in nature and appropriate information about each resident was transferred between services.

Each resident had an assessment of need and personal plan in place. Residents had access to the support of a keyworker and there was evidence that they were meeting regularly to review aspects of their support plans and to develop and review their goals. A number of residents described goals to the inspector and how they were being supported to reach these goals. The provider had systems in place to review personal plans six weekly. These reviews included an action plan identifying areas for improvement which were discussed with keyworkers who were responsible for implementing these changes. A number of residents' personal plans reviewed did not contain the most up-to-date information in relation to residents' care and support needs and were therefore not fully guiding staff to support them.

Residents were being supported to enjoy best possible health. They were accessing allied health professionals in line with their assessed needs. They had an assessment of need in place and there were systems in place to ensure that care plans were developed to guide staff to support them in relation to their healthcare

needs. However, the inspector viewed a number of documents in residents' personal plans which required review to ensure they contained the most up-to-date and to ensure that they were clearly guiding staff to support them. In addition, there was an absence of documentation to guide staff in relation to some healthcare needs which had been identified in residents' assessment of need. The inspector acknowledges that the provider was picking up on some of these documentation gaps in their audits and plans were in place to complete the required actions to ensure these were updated and reflective of residents' needs.

There were a number of restrictive practices in place in the centre and a restrictive practice register was in place. There was evidence that they were reviewed regularly and to ensure that the least restrictive practices were used for the shortest duration. The inspector reviewed evidence that a number of restrictions had been removed or reduced since the last inspection. Residents had access to allied health professionals and had support plans developed as required to support them. However, a number of plans reviewed were not comprehensive in nature and were not fully guiding staff in relation to proactive and reactive strategies to support residents. The inspector acknowledges this related to a small number of plans and that other plans reviewed were detailed and clearly guiding staff to support residents.

Residents were protected by the policies, procedures and practices relating to safeguarding in the centre. Allegations and suspicions of abuse were escalated and followed up on in line with the organisation's and national policy. Safeguarding plans were put in place and implemented as required. Staff were in receipt of training to support them to understand their roles and responsibilities in relation to recognising, reporting and escalating allegations and suspicions of abuse. Staff who spoke with the inspector were knowledgeable in relation to steps they would take to keep residents safe in the event of any suspicion or allegation of abuse. Residents had intimate care plans in place which detailed their support needs. They were clearly guiding staff to support them in line with their wishes and preferences. Safeguarding was discussed regularly in the centre to ensure each staff was familiar with safeguarding procedures and plans in the centre. It was discussed during daily handovers, at staff meetings and was a standing agenda item during staff's supervision meetings.

There were policies and procedures in relation to risk management and there was a risk register in place. There was evidence that it was reviewed and updated regularly. Residents had individual risk management plans in place and there was evidence that these were reviewed and updated in line with learning following incidents. However, the inspector reviewed a number of risk assessments which contained conflicting information and which required review to the control measures listed were appropriate and available. There were systems in place to ensure that incidents in the centre were recorded, reviewed and followed up on. There was evidence that learning following these reviews was shared across the team at handover and during staff meetings.

Suitable fire equipment was provided in the centre and serviced when required. There were adequate means of escape and emergency lighting in place in key areas. There was a procedure in place for the safe evacuation of the centre and it was on

display. Each resident had a personal emergency evacuation plan in place which outlined the support they required, if any, to evacuate safely in the event of an emergency. There was an emergency plan in place which had recently been reviewed and updated in line with learning following a recent emergency in the centre. There were regular fire drills held and staff were trained in relation to what to do in the event of a fire. The appropriate records kept in relation to drills, fire alarm tests, fire-fighting equipment, and checks of escape routes, exits and fire doors.

Regulation 17: Premises

The centre was clean, comfortable and designed and laid out to meet the number and needs of residents in the centre. The provider had identified areas for further improvement in the centre and plans were in place to complete the required works.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide available for residents in the centre. It contained the information required by the regulations and was being reviewed as required.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Transitions and discharges were planned and completed in a safe manner. Detailed transition plans were developed and detailed steps involved in supporting residents to transition to and from the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk register and evidence that it was reviewed and updated regularly in line with learning following incidents in the centre. General and individual risk assessments were developed as required. However, a number of risk assessments required review to ensure they did not contain conflicting information and to ensure

that they contained relevant and appropriate control measure.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were appropriate fire management systems in the centre and evidence that equipment was maintained and regularly serviced. Staff were completing training and refresher and each resident had a personal emergency evacuation plan in place. There was evidence of regular fire drills in the centre and that the emergency plan was reviewed and updated following learning from untoward events.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Resident had assessments of need and personal plans in place. They were supported by a keyworker and there was evidence of their involvement in the development and review of their personal plans. However, a number of personal plans required review to ensure they were consistent with residents' assessment of need and clearly guiding staff to support residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were being supported to access allied health professional in line with their assessed needs. For the majority of residents, support plans were developed in line with their assessed needs. However, health action plans were not in place for a small number of residents for some of their identified healthcare needs.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents had access to allied health professionals in line with their assessed needs. The majority of residents had detailed support plans in place to guide staff to support them. However, some residents' plans required review to ensure they

were sufficiently detailed to guide staff to support them. Restrictive practices were reviewed regularly to ensure the least restrictive measures were in place for the shortest duration.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were protected by the safeguarding policies, procedures and practices in the centre. Allegations of abuse were reported and followed up on in line with the organisation's and national policy. Staff were in receipt of training and residents who spoke with the inspector stated that they felt safe in their home.

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	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Willows OSV-0003385

Inspection ID: MON-0028644

Date of inspection: 13/02/2020

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 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • The Person in charge will review the contracts for provisions of service for all residents and update in relation to ensure they are reflective of the arrangements in place regarding Fee's. • The Contract of Provision of Services will be reviewed with the Residents and Stakeholders where required in line with the Policy on admissions for the Centre.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The Person in Charge will review all risk assessments to ensure that there is no conflicting information along with always having the relevant and appropriate measures in place for staff's guidance. • The Person in charge will endeavor to discuss all relevant risks daily with staff during handovers. • Risk management will continue to be discussed at team meetings monthly. • The Person in Charge will continue to review all risk assessments on a regular bases to ensure all risks are reflective of current needs.	

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:
• The person in charge will ensure that a full review is completed with the Key works and residents regarding the comprehensive needs assessment and where actions are required, they will be implemented into the president's personal plans clearly outlining guides for staff to support the residents.
• The Person in charge will ensure communication of changes to personal plans are communicated to staff through daily handover where applicable
• Personal Plans will be reviewed and discussed at the team meetings with all staff and MDT attending
• Behavioral Specialist will also review Personal Plan to ensure all needs are covered within the resident's personal plan

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The person in charge will ensure that a full review is completed with the Key works and residents regarding the comprehensive needs assessment and where required all healthcare needs will be actioned and implemented in the residents personal plans and intimate care plans to guide staff to support residents with all their healthcare requirements.
• All health care needs will be monitored by the PIC in line with policies and procedures
• All Updates to Care plans and intimate care plans will be discussed through handover and the Centre team meetings to staff

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The person in charge will ensure that a full review is completed on all personal plans to ensure they were sufficiently detailed to guide staff to support our residents.
• Behaviour support plans for residents will be reviewed in full to ensure that they guide staff practice.

• The person in charge will discuss all personal plans monthly at team meetings highlighting any changes and actions required.
• Behavioral Plans and Personal plans will be communicated through handover also to highlight changed to guide staff to support residents

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 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	30/04/2020
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	30/04/2020
Regulation 05(4)(a)	The person in charge shall, no later than 28 days	Substantially Compliant	Yellow	30/04/2020

	after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/04/2020
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.	Substantially Compliant	Yellow	30/04/2020