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:	Tateetra
Name of provider:	Praxis Care
Address of centre:	Louth
Type of inspection:	Short Notice Announced
Date of inspection:	26 July 2023
Centre ID:	OSV-0008032
Fieldwork ID:	MON-0033831

About the designated centre

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

Tateetra House is a designated centre situated on the outskirts of a large town in County Louth. The centre provides individualised supports to one resident who requires support with their health and mental health needs. The premises comprises of two bedrooms, a large kitchen dining area, a sitting room, staff office, one bathroom and one shower room. There is a large garden to the back of the property where there is a large decking area. To the side of the property there is a garage and a sheltered smoking area. The staff mix comprises of support workers, a team leader and a person in charge. One staff is on duty every day and at night on a sleep over basis. The resident does not attend a formal day service, preferring to decide what activities they want to do each day themselves.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	1

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
Wednesday 26 July 2023	09:00hrs to 18:30hrs	Anna Doyle	Lead
Wednesday 26 July 2023	10:30hrs to 18:30hrs	Raymond Lynch	Support

What residents told us and what inspectors observed

Overall, the inspectors found that there were some positive aspects to the care and support being provided in the centre. The resident was being supported to be independent and make choices about how they wanted to live their life. However, some improvements were required under governance and management, records, risk management, health care, medicine management and personal plans which is discussed in greater detail in section 1 and 2 of this report.

The inspection was short term announced, meaning that the registered provider was notified the day before the inspection based on the assessed needs of the resident. It was conducted by visiting the administrative buildings of the registered provider on the morning of the inspection to review records and in the afternoon the inspectors visited the centre to meet with the resident.

Over the course of the inspection, inspectors met with the person in charge, the head of operations, the team leader and the resident. The resident required a lot of reassurance and staff were observed to be understanding and patient of this. They were calm and reassuring when speaking with the resident at all times.

This centre provides bespoke residential care to one resident. It was evident that the resident lead the way in which they managed their life and they make their own decisions on a day to day basis. The staff, senior managers and the person in charge were transparent and demonstrated a commitment to supporting the rights of the resident. However, due to the resident's assessed needs the resident themselves did not always recognise these supports as being positive and as a result the resident reported to inspectors that they were not happy living in the centre and did not feel safe. The inspectors observed from records reviewed, that this was an ongoing concern that the resident raised through their interactions with allied health professionals, staff medical professionals and their advocates.

The resident was keen to meet with the inspectors about their dissatisfaction with this centre and reported a number of concerns. The resident was assured that these concerns would be reported to a senior manager the day after the inspection in order for the senior manager to follow up. This was completed and an inspector outlined those concerns to the head of operations the day after the inspection.

The inspectors found that the resident had access to numerous external support who they met regularly. For example, they had the opportunity to meet with an advocate and they were able to raise concerns to relevant public bodies, allied health professionals and key stakeholders. All concerns raised were listened to and followed up by the registered provider and relevant stakeholders. Notwithstanding, this the resident was still unhappy living in the designated centre. This was discussed with the head of operations the day after the inspection and they stated they would conduct a review of this.

The premises were large, spacious and decorated to a high standard. The resident had their own bedroom and en suite bathroom which the resident liked to clean and maintain themselves. The resident explained their day to the inspectors and said they choose when to get up in morning, looked after their own personal care, cleaned their room and had breakfast. During the day they liked to visit the nearby town and liked meeting friends. They said they enjoyed placing bets on the Grand National and football matches. The resident also spoke about going to coffee shops, the shopping centre and going to a charity shop where they helped out.

Staff spoken with informed the inspectors that, the resident generally liked to go on day trips with staff and they were planning to go to Dublin on Christmas eve to enjoy the atmosphere this year. Christmas was a very special time for the resident and they liked to plan things early to celebrate it.

The resident identified four staff members that they liked and said that they were very good to them, they spoke about some of the other staff that supported them, like a behaviour support specialist and the statutory key worker and some of their doctors. The resident explained about a doctors appointment they had coming up and how they liked this doctor.

The resident was supported to be independent and managed their own finances, medication and how they spent their day. Their personal plan outlined a number of things that they did not want in the centre and there was information available to inform them about things that were happening, such a easy to read information and menu plans. This was respected by the staff team and informed the inspectors that the residents preferences were listened to.

The next two sections of the report outline 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 residents lives.

Capacity and capability

Overall, the inspectors found that improvements were required in the governance and management of the centre, records, risk management, personal plans, medicine management and health care records.

There was a defined management structure in place. The person in charge had the support of a team leader who had oversight of some of the care practices in the centre. The person in charge reported to the head of operations, they met at least monthly to review and discuss issues in the centre.

The registered provider had conducted audits in the centre to ensure that the services provided were safe. However, improvements were required to some of the audit documents and the business continuity plan for the centre. In addition, as referenced under risk management and records, the providers system for managing

risks and records needed to be reviewed to ensure a safe service for the resident.

A review of a sample of rosters from April and June 2023 indicated that there were sufficient staff on duty to meet the needs of the resident as described by the person in charge. Additionally, from a small sample of files viewed, staff had Garda vetting and references on file. It was observed however, that the lone working risk assessment required review and updating. This issue is discussed under regulation 26: risk management.

From a sample of training records viewed, the inspectors found that staff were provided with training to ensure they had the necessary skills to respond to the needs of the residents. For example, staff had undertaken a number of in-service training sessions which included; safeguarding of vulnerable adults, fire safety, manual handling, basic first aid, medication management, positive behavioural support and children's first. From speaking with one staff member, inspectors were assured that they had the experience and knowledge required to meet the needs of the resident.

The inspectors found that records stored in the centre required significant review. For example, there was a large amount of records stored in relation to the residents care and support, the inspectors found that as a result of this, some key issues in relation to the residents care and support were not always followed up. Some key health care recommendations had not been followed up with the relevant parties. For example; it was noted in the residents plan that they would benefit from a specific medicine to manage their anxiety, however, there were no up to dated records in place to ensure this was being followed up.

Regulation 14: Persons in charge

The person in charge had the necessary skills and experience to manage the centre.They had only recently been appointed to the centre and demonstrated a good knowledge of the needs of the resident living in the centre and promoted a service that was person centred.

At the time of the inspection they were responsible for another centre under the remit of this provider. The inspector found that this did not impact the oversight and management of this centre at the time of the inspection.

Judgment: Compliant

Regulation 15: Staffing

A review of a sample of rosters from April and June 2023 indicated that there were sufficient staff on duty to meet the needs of the resident as described by the person

in charge on the day of this inspection.

Over a 24 hour period, the resident had 1:1 staffing support from 07.30 am to 11.00 pm every day and a sleep over staff was available in the centre from 11.00 pm to 07.30 am. This meant that a staff member was present in the centre on a 24/7 basis.

Additionally, from a small sample of files viewed, staff had Garda vetting and references on file.

As identified above, it was observed that the lone working risk assessment required review and updating. This issue was discussed under regulation 26: risk management.

Judgment: Compliant

Regulation 16: Training and staff development

From a sample of training records viewed, the inspector found that staff were provided with training to ensure they had the necessary skills to respond to the needs of the residents.

For example, staff had undertaken a number of in-service training sessions which included;

- safeguarding of vulnerable adults (to include the National Standards for Adult Safeguarding)
- open disclosure
- fire safety
- manual handling/intimate load handling
- basic first aid
- care of medication (to include a medication competency assessment)
- personal safety
- children's first
- positive behavioural support
- risk assessment
- personal care
- personality disorder training and,
- complaints management.

Staff had also undertaken training in a number of infection prevention and control (IPC) related courses to include:

- infection prevention and control
- hand hygiene
- personal protective equipment (PPE) and,

- standard and transmission based precautions.

Additionally, staff were also provided with training in the following:

- Applying a Human Rights Based Approach in Health and Social Care: Putting National Standards into Practice
- The Assisted Decision-Making (Capacity) Act 2015 and,
- The National Consent Policy.

It was also observed that the team leads/person in charge were provided with additional training in:

- supervision for staff and,
- conducting appraisals.

From speaking with one staff member and the person in charge, inspectors were assured that they had the experience and knowledge required to meet the needs of the resident living in this centre.

Judgment: Compliant

Regulation 21: Records

Information governance arrangements to ensure that all record-keeping and file-management systems were in place to deliver safe and effective care were not in place. There was a large amount of records stored in relation to the residents care and support, the inspectors found that as a result of this some key issues in relation to the residents care and support were not always followed up. Some key health care recommendations had not been followed up with the relevant parties. For example; it was noted in the residents plan that they would benefit from a specific medicine to manage their anxiety, however there were no up to date records in place to assure how this was being followed up.

The records, as required by the regulations, were not all of good quality, accurate, comprehensive or up to date. For example; protocols in relation to seeking assistance when the resident did not take their medicines differed between seeking advise after 2 days or 3 days.

The risk assessments in place were not comprehensive.

The daily records and other records that included consultation with doctors and other relevant third party personnel, were vast and it was difficult to assess what the most relevant information was in a timely manner.

Judgment: Not compliant

Regulation 23: Governance and management

There was a defined management structure in place which consisted of a person in charge. The person in charge had the support of a team leader who had oversight of some of the care practices in the centre. The person in charge reported to the head of operations who they met at least monthly to review and discuss issues in the centre.

The registered provider had systems in place to audit the care and support being provided in the centre. When audits were conducted they were collated on a quality improvement plan which was updated when actions from audits were completed. On the day of the inspection this document was not up to date and some of the actions had not been completed.

In addition, the contingency business plan had been updated recently but included information that was out of date. For example; the contingency plan outlined measures in place to manage COVID-19 in the centre, that were no longer required to be completed and not in line with current practices. While this did not pose a risk to the resident at the time of the inspection, they required review.

In addition, the providers system for managing risks and records needed to be reviewed to ensure a safe service for the resident.

The registered provider had completed a six monthly unannounced quality and safety review of the centre as required by the regulations to monitor and review the quality and safety of care.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of incidents the had occurred in the centre over the last year, informed the inspectors that, the person in charge had notified the Health Information and Quality Authority as required under the regulations.

Judgment: Compliant

Quality and safety

Overall, the centre was homely, spacious and was maintained to a very good standard. There were stringent measures in place to manage safeguarding issues.

Improvements were required in risk management, personal plans, medicine management and healthcare needs.

The inspectors found that the management of risk in the centre required significant review as some potential risks had not been risk assessed in the registered providers risk register. For example; lone workers and the management of medicines had not been updated or reviewed following adverse incidents in the centre. In addition, the inspectors found that following review one adverse incident which had occurred in May 2023 all recommendations had not been implemented. For example; the review recommended an MDT meeting should be conducted along with a review of the resident's behaviour support plan. However, neither of these had occurred following this incident. A precursor to this incident was that, the resident was awaiting a response from a consultant about whether surgery was required, however, there was still no update to this at the time of the inspection.

The residents individual management plans had also not been updated to reflect changes in care needs, they were not comprehensive and did not always include control measures to mitigate risks.

The resident had a personal plan in place which included an assessment of need. Support plans were in place to guide practice. However, at the time of the inspection, there was confusion over whether the resident had a mental health diagnosis, despite the fact that it was recorded in their assessment of need that the resident had a number of mental health concerns. This required review.

The resident was supported for the most part with their health care needs and had access to a range of allied health care professionals, to include GP, psychiatry and a behaviour specialist. The resident had been informed of, and had accessed health screening programmes and vaccination programmes available in the community. However, at the time of the inspection, there were no records to support whether the resident's required surgery had been agreed or not. There was also no evidence to support whether a medicine prescribed for the resident in relation to their mental health needs had been approved or followed up with the ward of court systems.

The registered provider had medicine management practices in place to maintain oversight of some of the medicines stored in the centre. A self assessment report had been completed which indicated that the resident was independently able to manage their own medicines. Some 'as required' (PRN) medicine was prescribed for the resident which was stored separately. However, one of the medicines stored did not have the appropriate seals in place. This had been reported by staff, however, it had not been returned to the pharmacy at the time of the inspection.

Systems were in place to safeguard the resident and where or if required, safeguarding plans were in place and at the time of this inspection there were three active safeguarding plans on the resident's file. From talking to staff and reviewing documentation, the inspectors found the issues identified had been responded to in line with the centre's policy and protocol, had been escalated to the safeguarding team and had been notified to the Health Information and Quality Authority as required. Additionally, interim safeguarding plans were in place to promote the

residents safety and well-being.

Due to the residents presentation they regularly made allegations about staff working in the centre. The inspectors found that, there was a protocol in place to manage these allegations and this protocol had been agreed with the safeguarding team. Staff spoken with were aware of this issue and how to respond to it in line with the agreed protocol. Additionally, from a small sample of files viewed, staff had training in safeguarding of vulnerable adults, children's first and open disclosure.

The registered provider had fire safety precautions in place. Staff had been provided with training in fire safety.

Regulation 17: Premises

The property was well maintained, clean and decorated to a good standard. The resident had their own bedroom which was decorated in line with the residents' preferences.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management systems in the centre required significant review as the records and control measures listed to mitigate risk did not provide assurances that risks were being managed effectively, that risk assessments were reviewed following adverse incidents or that risks were effectively mitigating or reducing risks in the centre.

The improvements required included:

- a lone workers risk assessment had not been updated following an adverse incident in the centre to assure that adequate staffing was in place at all times
- a review of an adverse incident recommended that an MDT meeting should be conducted and a review of the residents personal plan should take place. However, neither of these had occurred following this incident in May 2023. A precursor of this incident was that the resident was awaiting a response from a consultant about whether surgery was required, however there was still no update to this at the time of the inspection.

The resident had over thirty individual risk management plans which were not reviewed in line with incidents that were occurring in the centre. For example; a risk management plan on the resident's risk of not complying with medication in the centre had not been reviewed and did not include controls in place to manage the

potential risks in the centre. The inspector observed medicines that were in a residents bedroom which had not been returned to the pharmacy in line with the residents self assessment tool. Some incidents in relation to the management of medicines had not been recorded as an incident on the providers incident management system and it had not been risk assessed that the resident carried two doses of this medicine while they were out in the community even though in an emergency the resident only required one dose.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had fire safety precautions in place. Staff had been provided with training in fire safety. Fire fighting equipment and fire safety measures such as fire extinguishers, fire blankets and emergency lighting were installed and had been serviced recently. A personal emergency evacuation plan was in place to guide staff practice.

A sample of documentation informed the inspector that staff undertook daily, weekly and monthly checks on fire safety measures and where required, reported any issues or faults. Fire drills had been conducted to demonstrate that resident and staff could safely evacuate the centre in a timely manner.

The actions from the last inspection had been addressed. The registered provider has installed a fire exit door in the residents bedroom to assure a safe evacuation of the centre in the event of a fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had medicine management practices in place to maintain oversight of some of the medicines stored in the centre. A self assessment report had been completed which indicated that the resident was independently able to manage their own medicines. Some as required medicine was prescribed for the resident which was stored separately. However, one of the medicines stored did not have the appropriate seal on it. This had been reported by staff, however, it had not been returned to the pharmacy at the time of the inspection.

Notwithstanding, the fact that the resident was independent in managing their own medicines as discussed under risk management some aspects of this needed to be reviewed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The resident had a personal plan in place which included an assessment of need. Support plans were in place to guide practice. However, at the time of the inspection, there was confusion over whether the resident had a mental health diagnosis, despite the fact that it was recorded in their assessment of need that the resident had a number of mental health concerns.

Judgment: Substantially compliant

Regulation 6: Health care

The resident was supported for the most part with their health care needs and had access to a range of allied health care professionals, to include GP, psychiatry and a behaviour specialist. The resident had been informed of, and had accessed health screening programmes and vaccination programmes available in the community.

However, at the time of the inspection, there were no records to support whether the resident's surgery had been agreed or not. There was also no evidence to support whether a medicine prescribed in relation to the resident's mental health had been approved or followed up with the ward of court systems.

Judgment: Substantially compliant

Regulation 8: Protection

Systems were in place to safeguard the resident and where or if required, safeguarding plans were in place. Policies and protocols were in place to respond to any safeguarding issue arising in the centre.

Additionally, the following supports were in place to promote the residents overall safety and well-being:

- easy to read information on equality, advocacy and human rights was available in the centre
- resident meetings were being facilitated (where staff explained and discussed the concepts advocacy and human rights with the resident. Staff also explained and discussed the key principles of safeguarding with the resident to include protection and empowerment)

- regular key working sessions were being facilitated by staff with the resident (where staff discussed safety issues with the resident such as, how to stay safe in the community and how to keep their personal belongings such as finances and mobile phone safe)
- a complaints process was in place which the resident was aware of.

From a small sample of files viewed, staff had training in safeguarding of vulnerable adults, children's first and open disclosure, human rights and capacity legislation.

Additionally, the resident had recently been supported to attend an educational event on the Assisted Decision-Making (Capacity) Act 2015.

A staff member spoken with by one of the inspector was aware of how to respond to any safeguarding issue in line with the organisational policy and protocol on same.

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	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tateetra OSV-0008032

Inspection ID: MON-0033831

Date of inspection: 26/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 21: Records</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 21: Records:
The Registered Provider will ensure that records in relation to the resident, as specified in Schedule 3, are reviewed and contain all relevant up-to-date information and guidance. Third party contact sheets and Health Plan profile will be revised and information condensed into easily examined guidance. The Person In Charge will undertake a full review of the resident's personal plan, including their Assessment & Review tool, Everyday Living Plan and Risk Assessment & Management Plan. To be Completed by: 02/10/2023

The Person In Charge will ensure that a full review of the residents' medication takes place, during this process the Person In Charge will explore and clarify as to medication previously recommended for the treatment of anxiety. The Person In Charge will ensure that an up-to-date prescription record is in place to ensure all prescribe medication is outlined. To be Completed by: 02/10/2023

The Person In Charge has reviewed all protocols and guidance in relation to when the resident refuses to take their medication to ensure a consistent approach for staff. Completed: 01/08/2023

The Registered Provider will ensure that all record-keeping and file management systems are reviewed by the Head Of Operations on a monthly bases and by Quality and Governance within a 6 month period to ensure effective system are in place.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
</table>

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider shall ensure that management systems are in place within the designated centre, and monitor ongoing closure of actions on quality improvement plans (QIP) through the EMMR system on the Q&G dashboard. EMMR's and QIP's will be addressed with the Person In Charge during their bimonthly supervision and monthly through EMMR's by the Head of Operations.

The Actions from the current QIP will be closed off by 31/08/23.

The centre Business Continuity Plan will be reviewed and the Person In Charge will ensure that it contains up-to-date information and guidance in relation to Covid-19 management. To be completed by: 22/08/2023

The Registered Provider has set up a working group to review risk management policy to include a review risk escalation ratings and control measures. To be completed by: 30/09/2023

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Registered Provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risks. The Person In Charge will complete a full review of the resident's individual risk management plan, they will ensure that current risks are clearly identified and outline what control measure are in place to mitigate and/or manage these risks. The individual risk rating will be evaluated during this process. To be completed by: 02/10/2023

The person in charge will ensure that the lone working risk assessment is reviewed in full giving consideration to the last adverse incident in the centre. The person in charge will ensure that this document is reviewed going forward as deemed necessary. To be completed by: 22/08/2023

The Person in charge will ensure that an MDT meeting will take place to review the resident's needs. Same has been requested in the 16/08/2023. To be completed by: 31/10/2023

Following the MDT meeting the Person in charge will ensure the resident's personal plan is reviewed in full following any recommendations. To be completed by: 30/11/2023

The person in charge has reviewed the resident's management of their medication and a

new system has been implemented to have better oversight of medication management. Completed on: 27/07/23 The person in charge has ensured that the resident's medication has been returned to the pharmacy as per policy. Completed on: 29/07/2023 The Registered Provider will ensure that all record-keeping and documentation is accurately maintained, this will be monitored by the Head Of Operations on a monthly bases through EMMR's and by Quality and Governance auditors within a 6 month period. The Person in charge will ensure that all incidents will be recorded and escalated in line with organisational policy and procedures. The residents Risk Assessment and management plan will be reviewed and updated as required following incidents. Completed on: 15/08/2023	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The Person In Charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines. The Person In Charge shall ensure that out of date medication, and/or other medication that is to be returned are stored in a secure manner that is segregated from other medicine and disposed of in line with organisational policy and procedures. Completed: 29/07/2023 The Person in charge has ensured that they received appropriate seal for the medication that was stored. Completed: 29/07/2023 The Peron in Charge has ensured that all medication that was not in use was returned to the pharmacy. Completed: 27/07/2023	
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 shall review the residents personal plan and ensure that their	

diagnoses is clearly documented with an agreed support plan outlined, linking with relevant health care professional during this process. To be completed by: 02/10/2023

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Person in charge has linked in with the surgical team on the 16/08/2023
To advocate on behalf of the resident and ensure a treatment plan is actioned. To be completed by: 02/10/2023

The person in charge will ensure that the resident's health care needs will be captured in the resident's Health Profile and Passport Plan, this will be reviewed by the Clinical Lead to ensure all healthcare needs are addressed and that there are effective supports in place. To be Completed: 31/10/2023

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 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	02/10/2023
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.	Substantially Compliant	Yellow	30/09/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	30/11/2023

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	29/07/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in	Substantially Compliant	Yellow	02/10/2023

	need and circumstances, but no less frequently than on an annual basis.			
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	31/10/2023