Praxis Care Rush, OSV-0003417, 02 May 2018

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Praxis Care Rush
Name of provider:	Praxis Care
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	02 May 2018
Centre ID:	OSV-0003417
Fieldwork ID:	MON-0021306

About the designated centre

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

Rush is a residential centre which accommodates five adult residents with an intellectual disability. There are currently, four gentlemen and one lady residing in the centre. Four residents live in the centre on a full time basis and one resident is on a shared care agreement.
Rush is a large detached six bedroomed house with a spacious kitchen come dining room, living room and utility. There is a large back garden to the rear of the property. It is situated in a coastal town in County Dublin and close to local amenities such as local beach, shops, restaurants, library, cinema, bowling and activity centre, and bus routes.
Residents are supported by staff 24 hours a day, seven days a week. The staff team comprises of a person in charge and support workers. Staffing in the centre is adjusted in line with residents' assessed needs.

The following information outlines some additional data on this centre.

Current registration end date:	14/09/2018
Number of residents on the date of inspection:	5

How we inspect

To prepare for this inspection the inspector or 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
02 May 2018	08:30hrs to 16:25hrs	Marie Byrne	Lead

Views of people who use the service

On the day of inspection, the inspector had the opportunity to sit with four residents and discuss what it was like to live in the centre. All four residents were complimentary towards the care and particularly the support they received from staff in the centre. Residents told the inspector about how they were supported to attend appointments, college, day services, meet friends and to access local amenities. Two residents described support they were receiving whilst seeking employment in their locality.

There were similar positive comments in the satisfaction questionnaires completed by residents prior to the inspection. In these questionnaires residents were complimentary towards the food, visiting arrangements, level of activities and availability of staff support in the centre. There were forums in place in the centre for residents to raise concerns such as the complaints process, residents' meetings, and keyworker meetings. Residents described the complaints process and their positive experiences in relation to utilising the complaints process in the centre.

The atmosphere in the centre was relaxed and homely and staff were observed to support residents in a kind and respectful manner. Three residents described plans to move out of the centre with the inspector. They said that although they liked living in the centre, they were looking forward to moving out and into their new homes.

Capacity and capability

Overall, the inspector found that the registered provider and person in charge were striving to ensure a good quality and safe service for residents in the centre. Although residents' experiences of living in the centre were overall positive, there were compatibility issues between a number of residents in the centre. The provider had recognised this and put plans in place to transition residents from the centre. However, the inspector found that improvements were required in the centre in relation to transition planning and the provision of information to residents around the process of moving from the centre. In addition, improvements were required in relation to accessibility in the premises and one resident's general welfare and development. The provider had put measures in place to complete most of the actions required following the last inspection.

The provider had systems in place to monitor the quality of care and support in the centre including an annual review of the quality and safety in the centre and six monthly visits completed by the provider or their representative. The inspector

found that learning and improvements were brought about as a result of the findings of these reviews. The provider had recognised that there were issues with accessibility in the premises and some compatibility issues with some residents in the centre.

There was a clearly defined management structure with distinct lines of authority and accountability. The person in charge was knowledgeable in relation to the care and support needs of residents and their responsibilities in relation to the regulations. Residents spoke fondly of the person in charge and the entire staff team in the centre. The person in charge was completing regular audit in the centre in relation to health and safety and medication management. There was also evidence that these audits were bringing about positive changes for residents in relation to their home and their safety. Staff meetings were held regularly and there was good attendance and a broad range of topics discussed at these meetings. There was evidence of actions and follow up from these meetings which were contributing to the quality and safety of care provided for residents in the centre.

The inspector found that there were sufficient numbers and an appropriate skill mix of staff to provide safe care and support for residents. The staff team were in receipt of support, supervision and training to ensure they had the skills and competencies to meet residents' needs. The inspector spoke with a number of staff in the centre who were knowledgeable in relation to residents' care and support needs. The inspector also observed numerous interactions between residents and staff and found residents' strengths, abilities and independence were encouraged at all times. Residents described how they had developed their life skills since moving into the house including taking more responsibilities for the running and upkeep of their home and independently partaking in meaningful activities in their local community. One resident described how prior to moving into the centre they would not have had the confidence to up skill or start the process of seeking employment in their locality.

There were effective systems in place for the receipt and management of complaints in the centre. There was a local complaints officer and evidence of review and follow in relation to complaints. Residents described their positive experience in relation to making complaints in the centre and how they were satisfied with how their complaints were dealt with.

Regulation 15: Staffing

The inspector found that there were enough staff with the right skills, qualifications and experience to meet residents' assessed needs. There were planned and actual rosters in place and evidence that staffing in the centre was changed in line with residents' support requirements. The information required by schedule 2 of the regulations were in place in the staff files reviewed by the inspector.

Judgment: Compliant

Regulation 16: Training and staff development

Staff in the centre had access to training and refresher training in line with residents' assessed needs. They were in receipt of good quality supervision and there was evidence that their opinion was considered in relation to their suggestions for improvements relating to residents' care and support in the centre.

Judgment: Compliant

Regulation 21: Records

There were systems in place to ensure that records in the centre were regularly reviewed and updated to ensure they were effective and reflective of residents' care and support needs. All the required records were maintained and available in the centre.

Judgment: Compliant

Regulation 22: Insurance

There was evidence of a valid insurance certificate and written confirmation of insurance cover in the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures in the centre which identified the lines of authority and accountability. Some systems were in place to monitor the care and support for residents in the centre including an annual review of the quality and safety of care and six monthly visits by the provider. The inspector found that improvement was required in relation to the oversight and management of transition planning, the provision of information to residents, one resident's general welfare and development, and arrangements in place to keep residents safe.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

All residents in the centre had a contract of care which clearly outlined the services and facilities in the centre. All contracts had been signed by residents and/or their representative and outlined charges and additional charges for residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose in the centre was reflective of the services and facilities for residents in the centre. It contained all the information required in schedule 1 of the regulations and had been reviewed in line with the timeframe identified by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed untoward incident reports in the centre and found that all required notifications had been sent in line with the requirement of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were policies and procedures in the centre relating to complaints. There was a local complaints officer and evidence of investigation and appropriate follow up on complaints to the satisfaction of the complainant. All residents who spoke with the inspector were aware of how and who to make their complaint to if they so wish.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents lived in a clean and comfortable home. However, improvements were required to the design and layout of the premises as it did not meet all residents' needs. Improvements were also required in relation to keeping residents safe and one resident's general welfare and development. The provider had recognised the problems with accessibility in the centre and purchased a new premises. They had also recognised compatibility issues between a number of residents which were resulting in peer-to-peer safeguarding issues. They had put measures in place to complete most of the actions required following the last inspection.

The centre was found to be homely and clean throughout. In line with the findings of previous inspections there were areas in the centre which were not fully accessible for one resident. Improvements had been made since the last inspection to install ramps to improve accessibility. However, the resident had to exit their bedroom via a door to the garden to then enter the premises via the backdoor of the kitchen in order to access the rest of the downstairs of their home. The inspector spoke with the resident about current arrangements and they said they were managing at the moment but that they were looking forward to moving to a more accessible premises. The inspector also found that another bedroom was not of a sufficient size for long term use but acknowledged that the resident with the shared care agreement was only using the room on a part time basis. There were areas in the centre in need of painting and repair including cracked tiles in the main bathroom.

One resident was receiving the keys to their new home on the day of inspection. On speaking with the resident and reviewing documentation, there was evidence that the move was in line with their wishes, and that staff in the centre were supporting them through the process. However, there was no transition plan in place for this resident. The person in charge informed the inspector that a new premises had been purchased by the provider and that the other four residents in the centre would be transitioning to this new premises. On reviewing documentation and through discussions with the person in charge and person participating in the management of the designated centre the inspector found that there were no transition plans in place for these residents. This was discussed at feedback and the inspector was informed that definite plans were not yet in place relating to who would be transitioning out of the centre, and that once this was identified transition plans would be in place. The inspector acknowledged that these transitions plans were not in place as decisions were not yet made, but identified that there was no evidence of consultation with residents relating to the provision of services and support available in the alternative designated centre.

Residents had personal plans in place and there was evidence that they were developed with the resident, their representative and the relevant members of the multidisciplinary team. There was a keyworker system in place and residents described the support they received from their keyworker to develop and complete

their goals. A number of residents had and were attending college and were in the process of preparing for and seeking out opportunities for employment. There was evidence of many and varied activities for the majority of residents. However, one resident had limited opportunities to engage in meaningful community based activities due to their specific wishes around the use of transport. The provider was aware of the residents wishes relating to transport and had initial suggestions in relation to meeting their needs in line with their wishes. However, this had not progressed at the time of inspection.

Each resident was supported to enjoy best possible health. Residents' healthcare needs were appropriately assessed and care plans were in place in line with these assessed needs. Each resident had access to appropriate allied health professionals in line with their assessed needs.

The inspector found that the provider and person in charge were promoting a positive approach to responding to behaviours that challenge in the centre. Restrictive practices were regularly reviewed in the centre and one restrictive practice was recently discontinued in line with one of these reviews.

The inspector found that the provider was putting some measures in place to protect residents in the centre. There had been a number of peer-to-peer incidents which were impacting negatively on a number of residents. Safeguarding plans were developed as necessary in conjunction with the designated officer. The provider had recognised compatibility issues in relation to some residents in the centre following these safeguarding concerns and a number of complaints from residents. They were supporting residents to stay safe by implementing safeguarding plans while sourcing alternative accommodation for residents. However, incidents were still occurring in the centre.

Residents were protected by policies, procedures and practices in place relating to health and safety and risk management. There was a system in place for keeping residents safe while responding to emergencies and there were also systems in place to identify, record, investigate and learn from adverse events and incidents in the centre.

The inspector also found that the provider had put measures in place against the risk of fire in the centre including equipment for detecting and extinguishing fires. Works had been completed in the centre to install emergency lighting, thumb locks on doors and self-closing brackets on some doors. Fire drills were completed regularly and each resident had a personal emergency evacuation plan (PEEPs) in place. There was evidence that PEEPs were updated following learning from fire drills.

Residents were protected by policies, procedures and practices in relation to medicines management. Residents had self-medication assessments in place which were completed with and signed by residents. These assessments outlined what supports residents required if any. Residents also had medication care plans in place and medication audits were completed regularly in the centre.

Regulation 12: Personal possessions

The inspector found that residents retained and stored their belongings in line with their wishes. There was limited storage in one of the bedrooms but the person in charge outlined arrangements in place to minimise the impact of this on the resident.

Judgment: Compliant

Regulation 13: General welfare and development

Overall, residents in the centre were supported to engage in activities in line with their wishes such as attending college, day services and other activities of their choosing. A number of residents were being supported to complete work experience and apply for work in the local community. However, one resident with specific wishes in relation to transport options did not have access to some activities of their choosing in the community.

Judgment: Substantially compliant

Regulation 17: Premises

The design and layout of the leased premises did not meet the all residents' needs in the centre as outlined in the body of the report. The provider was aware of this and had purchased a new premises. There were also areas of the centre in need of repair and painting.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

There was no transition plan in place for a resident who was currently transitioning from the centre. Also further transitions were planned in the centre and there was no evidence of consultation with residents relating to the provision of services and support available in the alternative designated centre, despite two residents informing the inspector that they were moving into this new designated centre.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were policies and procedures in the centre to identify, assess and manage risk. There was a risk register in place which was regularly reviewed and updated. There were systems in place for identifying and learning from incidents in the centre which were resulting in positive outcomes for residents.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place to detect contain and extinguish fires in the centre. Fire drills were completed regularly, equipment was serviced in line with the requirements of the regulations, and there was evidence of learning leading to improvements following fire drills.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents in the centre were protected by the policies, procedures and practices relating to medicines management in the centre. Residents had medication assessments and care plans in place and one resident was being supported to take responsibility for their own medicines in line with their assessment and wishes.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan which outlined their likes, dislikes, goals, and care and support needs. Care plans were in place in line with residents' assessed needs. There was evidence that residents' maintained independence and were supported to develop life skills in line with their wishes. There was evidence of regular review to ensure residents' personal plans were effective.

Judgment: Compliant

Regulation 6: Health care

Residents' healthcare needs were appropriately assessed and supported through appropriate care planning in the centre and they had access to allied health professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' behaviour support needs were recognised and supported in the centre. It had been recognised that one resident required additional support and had recently been reviewed by a behaviour specialist. Restrictive practices in the centre were regularly reviewed and one restrictive practice had recently been removed following one of these reviews.

Judgment: Compliant

Regulation 8: Protection

There were some systems in place to keep residents safe in the centre. However, there had been a number of peer-to-peer safeguarding incidents occurring which were negatively impacting some residents in the centre. Safeguarding plans were put in place and the provider was in the process of securing alternative accommodation for some residents. However, peer-to-peer safeguarding incidents were still occurring.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
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 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	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	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Praxis Care Rush OSV-0003417

Inspection ID: MON-0021306

Date of inspection: 02/05/2018

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:

Within the centre there is a defined management structure in place and the centre is resourced to ensure care and support is delivered in accordance with the Statement of Purpose. There is a staff rota with safe staffing levels maintained.

Each year, an annual review of the service is carried out which captures the quality and safety of the care and support being provided within the center. Residents' complete annual surveys and family representatives and stakeholders also complete questionnaires, the feedback provided in both is captured in the annual review report. Feedback on the day is also obtained from the residents when they meet with the individual carrying out the review.

A monthly monitoring visit is completed by management, mainly head of operations, providing a consistent review and monitoring of the service being provided.

An unannounced inspection is carried out at least every six months by the organizations Quality and Governance Department. Details of the quality and safety of the care and support being offered within this centre is detailed in this report along with an action plan to address any areas of improvement which have been identified. A hard copy of both the six monthly unannounced inspection and the annual review report is stored and available for those who may request same.

Staff receive training on the regulations and standards which govern the service we provide. This programme is developed by the learning and development department of the organization to ensure that the quality and safety of care and support is being maintained.

Through supervision / annual appraisal each team member's performance is managed, and they are supported and given the opportunity to further develop their knowledge and skills. Monthly team meetings take place whereby we discuss organizational policies such as the whistleblowing process, escalation of risks and raising concerns.

Transition plans for each Resident of the center have been devised and are working documents which captures all discussions, plans and support being offered to each of the Residents in preparation for the move to their new home. These plans shall be reviewed and monitored during monthly supervision with PIC and Head of Operations.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

Each resident has an individualized Everyday Living Plan and Risk Management Plan which details the care and support which is provided by the staff team on a daily basis. Each resident is identified a Key worker and at least every month they engage in a key working session. Through this system and daily conversations with the residents we identify their wishes and offer them the support they require to access facilities or participate in activities of their choice. Staff explore options available in the wider community to provide opportunities which help develop or maintain relationships.

The organization is currently exploring the option of obtaining a scheme vehicle which would promote the residents access to the activities available in their community. The costings for this request are currently being drafted by the finance department of the organization. In the interim alternative options are also being explored to promote access to the wider community.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

As the current property does not meet resident's needs, a new property has been purchased situated in a housing estate in the center of the village of Rush. The new property has been adapted so that the design and layout meet the aims and objectives of the service and the number and needs of the resident.

Within the center of Praxis Care Rush a maintenance book is maintained which captures any maintenance issues, the process of how it was resolved and the final outcome. As the property is a rented property, the PIC keeps in regular contact with the landlady of the house ensuring that the center is of sound construction and kept in good state of repair both externally and internally.

Once all the current residents of Rush move to their new premises areas of repair and painting of the house can be completed. There are cleaning schedules in place and residents are supported to maintain a clean property.

Each resident has their own bedroom, whereby they choose how they would like to decorate their room and receive the necessary support from staff to achieve same.

Equipment and facilities are maintained regularly and records of when such work is completed is stored within our Health and Safety Folder.

The PIC links in with the community occupational therapist. She is familiar with the current resident's needs of Praxis Care Rush and on occasions will visit the center. The Occupational Therapist will discuss necessary equipment or aids that may be available to the residents which will promote their full capabilities and independence. We continually strive to promote full capabilities and continue to link in with allied professionals should a change in need arise.

The current property of Praxis Care Rush does not meet the needs of the all the current resident's, therefore they shall be moving to a different property. Consideration shall be given to the future resident's needs who may wish to reside in Praxis Care Rush to ensure that the design of the centre enables all residents to access all areas.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
Transitional plan has been devised for each resident –

Residents devised and agreed on transitional plans in the format of a visual calendar. Both staff and the residents have a copy of this plan which clearly indicates which property the resident would be residing within over the forthcoming weeks. A template has also been devised which captures all the discussions and support being offered to ensure residents have all the services in place and support to settle into their new environment. As residents transition from one centre to their new home staff are providing information on services available and offering support to access same.

Residents desires to live independently and move into their own property is documented in Key Working Sessions and Annual Reviews and staff offer the support and advise required. Transitions are discussed, planned and agreed with both residents and their representatives and such discussions have been captured in recent annual reviews and key working sessions.

All information relating to discharge is captured in Transitional Plan -

Should a resident be temporarily absent from the designated center information is provided by the staff team to the individual responsible for providing the temporary care. We have Emergency Grab sheets / Kardex for hospital admissions and outgoing medication records for when medication needs to be administered.

The PIC and staff team have consulted with each resident about the future plan to move

and have involved them in the decoration of the new center and their bedrooms. All this input and involvement has been captured in each resident's transitional plan.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

Through monthly house meetings, key working sessions, daily conversation and social story work the staff team support each of the residents to develop the knowledge and understanding for self-care and protection.

The staff team are provided with necessary training to recognize all forms of abuse and are familiar with the reporting / escalating procedures, prevention, detection and response to abuse. The organizational and national safeguarding policy are adhered to and are available to each team member. All safeguarding concerns are shared with the Safeguarding Team outlining the investigation which took place, the findings and a proposed plan with measures to protect the residents.

Safeguarding plans are discussed during team meetings to ensure that the measures included are understood and implemented by the staff team.

All residents are made aware of the identified local safeguarding officer and there is a visual display in the communal area of the living area which identifies the local and champion safeguarding officer.

There is guidance available (policy and flowcharts) for the escalation of risk / concerns and discussions take place through supervision and team meetings whereby an open and transparent system of reporting is promoted. Any allegations made are investigated by the appropriate team (HR / Safeguarding)

Any resident who may require personal care has individualized intimate care plans for staff to follow, there is also an organizational policy in place for further guidance.

Staff are also striving to promote positives relationships within the house and are currently working alongside a Positive Behavioural Support Plan which has been introduced to offer the guidance, structure and support to the staff team. The Behavioural Consultant met with the staff team of Praxis Care Rush to discuss and ensure that it was understood by those who would be implementing same. Relationships between residents shall be monitored continually by the staff team, PIC and Head of Operations, whereby trends and patterns of untoward events and incidents shall be identified. Should relationships deteriorate, alternative suitable accommodation will need to be considered.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30.09.2018
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	IF	31.08.2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound	Substantially Compliant	Yellow	31.08.2018

	construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	IF	31.08.2018
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	31.07.2018
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential	Not Compliant	IF	31.08.2018

	services through:the provision of information on the services and supports available.			
Regulation 25(4)(b)	The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner.	Not Compliant	IF	30.06.2018
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31.07.2018