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:	Seirbhis Radharc an Chlair
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Announced
Date of inspection:	27 November 2024
Centre ID:	OSV-0005026
Fieldwork ID:	MON-0036780

About the designated centre

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

Seirbhís Radharc an Chláir provides a full-time residential service for up to eleven individuals of mixed gender, who are over 18 years of age, and have an intellectual disability and or autism. Residents may also present with complex needs such as physical, medical, mental health, mobility, and or sensory needs, and may require assistance with communication. Residents have the choice of a home based day service which includes linking with their local community, or attending day programmes in the area. Residents are supported by a staff team that includes social care leaders, social care workers and care assistants. Staff are based in the centre when residents are present. At night there is a staff member on waking duty in one house, and a staff member sleeps in the other house to support residents. Seirbhís Radharc an Chláir is made up of two houses in a rural area close to the coast. Both houses are spacious with large gardens, and in each house there is also self-contained accommodation for one person. All residents have their own bedrooms. The centre has transport available at each house, to facilitate residents to access the community in line with their wishes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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 27 November 2024	09:00hrs to 15:15hrs	Ivan Cormican	Lead
Wednesday 27 November 2024	09:00hrs to 15:15hrs	Anne Marie Byrne	Support

What residents told us and what inspectors observed

This was an announced inspection following the provider's application to renew the registration of this centre. The inspection was facilitated by the centre's person in charge, a senior manager and also a senior member of staff. Inspectors had the opportunity to meet with five residents, and with five staff members. As part of the inspection process, inspectors reviewed the progress made by the provider to address actions from the previous inspection, which was carried in March 2024. Although the provider had addressed some of these actions, this inspection found a significant decline in compliance, particularly in relation to risk management, staffing and the governance and management arrangements. In addition, concerns were raised with the provider in relation to medication administration practices. An immediate action was issued to the provider to review medication practices, and ensure that this area of care was safe and fit for purpose. These findings will be discussed in more detail later on in the report.

The centre comprised of two houses which were located in the countryside, within a short drive of Galway city. The houses were in close proximity to each other and provided care for up-to-eleven residents. At the time of this inspection, the centre was not operating at maximum capacity, and the provider had not identified any further residents for admission. One house catered for residents with moderate to high needs, and the other catered for residents with moderate needs. Some residents were assessed as requiring support in relation to specific health care needs, others required support with falls management, some required specific positive behavioural support, and all required staff support to get out and about within their community. Each house had a calm and welcoming atmosphere, and inspectors observed staff to be very pleasant in their approach to care. Residents were at ease in their company, and there were very friendly interactions throughout the course of the inspection.

On the day of this inspection, many of the residents remained at home, while others and gone out for the day with staff. One resident was having their breakfast upon the inspectors' arrival, while others were having a lie on, and some were being assisted by staff to get dressed for the day ahead. The other house in the designated centre supported residents with moderate needs, and an integrated service was in place for the majority of these residents, with one resident attending an external day service four days every week. A staff member spoke with one of the inspectors about the social interests of these residents which included attending art and music twice a week, others attended swimming lessons, they liked to go shopping, to go the cinema, to dine out and sometimes went bowling. Some of them had a keen interest in the Irish language, enjoyed puzzles and going for walks in their local area.

Although the centre was a pleasant place in which to live and residents' basic care needs were well catered for, this inspection highlighted that significant improvements were needed in relation to the staffing arrangements, particularly in

one of the houses. This house catered for residents with high needs, and the provider offered them an integrated service, whereby they received both residential and day services from the designated centre. However, inspectors found that the staffing arrangements in place in this house, did not promote community access or engagement in centre based meaningful activities, for these group of residents. Inspectors found that the lack of suitable staffing to support all of resident's individual needs had a negative impact on their personal development.

Medication and risk management formed a large part of the lines of enquiry for this inspection. This came as a result of a high volume of medication errors being reported to the provider, which the person in charge had brought to the attention of inspectors early on in the inspection. Inspectors reviewed the nature of these errors, and also the action taken by the provider in response to them. However, despite some action being implemented by the provider, there were significant concerns raised by inspectors in relation to the safety of medication administration practices. As earlier mentioned, this did result in an immediate action for the provider to address; however, other aspects of this medication management system when reviewed upon inspection, also indicated the requirement for the provider to conduct a full review of this aspect of their service. Again, this will be discussed further later on in this report.

While this inspection did identify some good areas of practice, there were a number of key aspects of this service which required significant review by the provider, so as to better the quality and safety of this service. Key failings were found to oversight arrangements, which were not enabling the provider to assure themselves that all aspects of this centre were operating at a safe and high standard.

The specific findings of this inspection will now be discussed in the next two sections of this report.

Capacity and capability

The provider had governance and oversight arrangements in place which ensured that many aspects of care were held to a good standard. The centre had a management structure with clear lines of authority and accountability, and inspectors found that one house comprising of this designated centre was well resourced in terms of staffing. However, inspectors found that the second house required significant improvements in terms of staffing, which had a negative impact in regards to community access for residents with high support needs. In addition, an immediate action was issued in regards to medication administration practices, and further issues of concern were found in relation to risk management. These issues will be discussed in the subsequent sections of this report.

The last inspection of this centre found that many areas of care were held to a good standard and that oversight arrangements promoted the safety and well-being of residents. Again, this inspection found positive examples of care and it was clear

that residents enjoyed their home. The actions taken by the provider to improve areas of case such as fire safety, restrictive practices and complaints had brought about a positive change, and these regulations were held to a good standard on the day of inspection. However, actions taken in regards to risk management and the administration of medications had not brought about sufficient change, and these areas required marked improvement on the day of inspection. In addition, the provider failed to ensure that one house was adequately resourced in terms of staffing. Inspectors found that this was having a negative impact on residents with high supported needs and adversely effected their personal development and also their access to the local community.

The provider had completed all internal reviews and audits as set out in the regulations and found that in general, a good level of care and support was offered. Inspectors found that improvements were required to these audits as they failed to identify issues with regard to staffing, risk and medication management. In addition, a resident's family member had raised concerns in the centre's most recent six monthly audit in regards to access to community based activities such as horse riding and swimming; however, these concerns had not formed a part of the associated actions to improve this area of care for residents.

Inspectors found that many areas of care were held to a good standard and that staff were kind and considerate when interacting with residents. However, lack of adequate staffing resources were having a negative impact on the delivery of care in one aspect of the centre.

Regulation 15: Staffing

Inspectors found that significant improvements were required with regard to the staffing arrangements in one aspect of this centre. Staff explained to an inspector that opportunities for community participation were impacted, due to the number of staff allocated to support residents on some days.

The person in charge stated that a post to facilitate resident's personal development and community access within the centre was not filled. An inspector found that this had a significant impact on residents. A sample of records reviewed for two residents, with high support needs, showed that they only had six community based activities each over a month long period, which included one week where there was no community access at all. In addition, activity trackers reviewed showed that areas of personal development such as cookery and arts and crafts were not occurring on a regular or planned basis. Furthermore, a resident's family member had raised concerns regarding access to community based activities such as horse riding and swimming; however, these concerns had not been addressed on the day of inspection.

An inspector also found an inconsistent approach to the allocation of staffing within one of these houses. A review of the rota over a five week period showed that the staff on duty ranged from two-to-five staff on any given day. An inspector found

that the allocation of two staff had the potential to impact upon safety within the centre, and the allocation of a three staff impacted upon residents' ability to access their community , as well as, the delivery of meaningful activities within the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had a mandatory and refresher training programme in place, which ensured that staff were informed and could meet the assessed needs of residents. Staff had completed mandatory training in areas such as safeguarding, fire safety and supporting residents with behaviours of concern. In addition, some residents who used this service required a high level of support and additional training in areas such as epilepsy and supporting residents with modified diets. two staff members had not recently completed refresher training in regards to epilepsy and the administration of rescue medication; however, the provider confirmed that these staff were scheduled to complete additional training subsequent to the inspection.

The provider ensured that staff attended both team meetings and individual supervision sessions with their respective line manager. Individual sessions were scheduled to occur twice yearly and team meetings were generally held on a monthly basis. Inspectors found that these arrangements ensured that staff had opportunities to discuss care practices and any concerns or issues which they may have.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that there were significant improvements required in regards to the governance and oversight arrangements in this centre. Actions taken in regards to issues raised on the last inspection, failed to bring about sufficient change and inspectors found a decrease in some aspects of the quality and safety of care provided. The provider had completed all required audits and reviews as set in the regulations; however, these actions did not identify issues raised on this inspection, with significant deficits found in relation to medication, staffing and risk management.

Serious concerns were raised on the day of inspection with regard to a substantial level of medication errors. Although, the provider was aware of these errors and additional measures were implemented, these measures did not prevent or reduce further errors from occurring. In addition, ongoing issues in regards to the management and administration of a controlled medication were again highlighted

on this inspection. Of concern to inspectors was the poor management of medications, and an immediate action was issued to the provider to review medication practices and ensure that this area of care was safe and fit for purpose.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of information in the centre indicated that all notifications had been submitted as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were no active complaints in this centre. The provider had appointed a person to manage all received complaints and information on how to make a complaint was clearly displayed in both houses.

Many of the residents who used this service were Irish speakers and the provider had adapted the user friendly information into the Irish language for these residents. This document was shared at residents' meetings which raised awareness on how to make a complaint.

Judgment: Compliant

Quality and safety

Residents' needs were well-known by all staff, and of those who met with inspectors, they spoke confidently about the care and support that each resident required. Good examples of care were found in relation to safeguarding arrangements, positive behavioural support, and also with regards to the promotion of residents' rights. However, this inspection did identify where considerable improvement was required on the part of the provider with regards to how they had implemented their own risk management system, in response to significant improvements required to medication management arrangements.

In the weeks leading up to this inspection, there were a number of medication errors reported, relating to various aspects of medication administration practices. The provider was aware of these and had organised additional medication training

for all staff, and had also placed emphasis on staff adherence to the medication management policy. However, this had not been effective in addressing the issue, with further medication errors continuing to occur. Due to the concerns raised by inspectors relating to the risk posed to safe administration of medicines in this centre, the provider was issued with an immediate action to address this. Furthermore, the provider was requested to provide assurances that they would immediately put plans in place to review all aspects of their medication management system, following further concerns raised by inspectors relating to some prescribing practices, and oversight of the centre's medication dispensing system.

In light of the failings identified to the provider's response to identified medication management related risks in this centre, this also raised concerns of the overall effectiveness of this centre's risk management system, in adequately responding to, addressing and monitoring for risk in this centre. There was a noted lack of urgency on the part of the provider to further review their overall management of risk in this aspect of their service, particularly where further medication errors occurred, clearly indicating to the provider, that the additional control measures which they had put in place, were not satisfactorily addressing the issue. A revision of monitoring systems was also required, as at the time of this inspection, medication management was not included within the centre's risk register, so as to allow this known risk in this centre, to be adequately assessed for, and monitored for improvement.

Overall, inspectors found that residents enjoyed their home which had a pleasant and homely atmosphere. However, poor practice in regards to risk and medication management had the potential to impact upon the safety of care which residents received.

Regulation 26: Risk management procedures

Following on from the last inspection, the provider had revised the way in which they were completing risk assessments in the centre, with a noted improvement to these observed by inspectors upon this inspection. However, the provider’s response to specific risks which they themselves identified in this centre, required significant improvement to ensure more robust action was taken when certain risks are identified.

This designated centre had repeated incidents being reported, relating to various aspects of medication administration practices. In response to these, the provider had put in place additional control measures; however, despite this, further medication errors of a similar nature continued to occur, indicating that this risk had not been appropriately mitigated. Given that the majority of the repeated incidents that the provider was aware of, were relating to risks relating administration practices, the provider had not given consideration to the implementation of more effective interim control measures during medication administration times, until such a time as the provider could assure themselves that this particular risk in this centre

had been rectified.

Furthermore, the oversight of risk in this centre required improved monitoring by local management. For example, although the person in charge was aware of the incidents occurring, they had no system in place for themselves to routinely review these for trending purposes. In addition, although they had a risk register available to them, risks pertaining to this centre's medication management were not included within this register, to support their management and monitoring of this fundamental aspect of this service.

Falls management was a large aspect of care provided in this centre, and although there was clear evidence that falls risk assessments were being reviewed on a regular basis, improvement was required to how falls risks were being assessed for. For example, the current system for this assessment process placed emphasis on the occurrence of injury as a result of a fall, rather than focusing on assessing for the risk of falls.

Judgment: Not compliant

Regulation 28: Fire precautions

The actions from the centre's last inspection had been addressed as the provider demonstrated that all fire doors would close in the event of a fire occurring.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The last inspection had identified where improvement was required to aspects of medication management. However, the provider had failed to ensure sufficient improvements were made since then, so as to bring them back into compliance with the regulations.

In recent months, a number of medication errors relating to administration practices, were reported to have occurred. The provider was aware of these and although they had taken some action to rectify, these actions were not robust enough to satisfactorily address the issue, resulting in further medication errors of a similar nature continuing to occur. Due to concerns raised by inspectors relating to the safety of medication administration practices in this centre, an immediate action was issued to the provider to put immediate additional control measures in place to assure medication was being safely administered to all residents. Secondly, the provider was also requested to give assurances that they would put immediate plans in place to fully review their medication management system. Before close of this

inspection, these assurances were received.

Further to this, significant other improvements were found to be required to this centre's medication management system. Some prescribing errors were also identified by inspectors, to include, an emergency medicine prescribed for one resident, which did not outline the maximum dose or route of administration. For another resident, the dose of a regular medication which they were prescribed, was calculated each week based on their weight. However, there was no robust system in place to ensure each weekly prescription of this medicine was being appropriately recorded. In addition to this, the protocol guiding on the prescribing and administration of this particular medicine, was not signed by the prescriber.

Concerns were also raised by inspectors in relation to the blister pack medication system which was in use in this centre. For instance, there was no system provided so that staff they could clearly identify each medication that was dispensed within each pack. In addition, although weekly checks were being completed of these blister packs against prescribing records upon receipt from pharmacy, in the absence of a system to identify each medicine, it was unclear how the provider was assuring themselves that all medicines were being received from pharmacy, as prescribed. Furthermore, this weekly check had also failed to identify the specific prescribing errors, which were identified upon this inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' needs were re-assessed for on a regular basis, and personal plans were then developed to guide staff on the various aspects of care and support that each resident needed. Two residents' files were reviewed as part of this inspection, and there was clear evidence that where changes to residents' care and support needs arose, that associated assessments and personal plans were updated accordingly by staff.

Judgment: Compliant

Regulation 7: Positive behavioural support

There had been recent changes to a resident's individual needs and the provider was in the process of reviewing their positive behavioural support plan. Other residents who used this service required minimal interventions with regards to behaviours of concern. Staff members who met with inspectors had a good understanding of resident's individual needs and also of the use of restrictive

practices in the centre.

There was good oversight of identified restrictive practices with reviews conducted by the provider's human rights committee ensuring that these practices were evidenced based and a requirement of care. In addition, some of these practices had been removed since the last inspection and it was clear that the least restrictive measure was implemented at all times.

Judgment: Compliant

Regulation 8: Protection

There were no safeguarding plans required in this centre, and residents who met with the inspectors stated that they felt safe in their home and that staff were nice. Inspectors also observed staff interacting with all residents in a warm and caring manner.

Information in relation to safeguarding was clearly displayed and the provider had appointed a designated person to manage all allegations of abuse. In addition, the provider had ensured that vetting disclosures were in place for all staff, who had also completed safeguarding training. Overall, inspectors found that safeguarding was well promoted by the actions and measures implemented by the provider.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Seirbhis Radharc an Chlair OSV-0005026

Inspection ID: MON-0036780

Date of inspection: 27/11/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In accordance with Regulation 15(1) to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre, the Person in Charge is completing an overall review of the roster in the designated centre. This review is being completed in line with a review of the assessed changing needs of the residents. The assessed minimum staffing of three people is being implemented. This has been implemented with the use of agency staff at present until two staff return from leave by 31/01/2025. The day service post is in the recruitment process, this will be a post Monday- Friday for seven hours per day, additional to the three minimum core staff on duty. It is anticipated to have this filled by 28/02/2025. This post is currently in place with existing and agency staff and is highlighted on the roster for each day. In accordance with Regulation 15 (4) in order to ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained, the person in charge will accurately reflect the day programme staff on the roster and the roster review will result in staff being rostered at a consistent level across the whole week, in line with the assessed needs of the residents.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In accordance with Regulation 23(1)(a) to ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of	

purpose, the Person in Charge is carrying out a review of the roster and recruitment for a vacant day service post. Following this, day service staff will be appointed and staff will be consistently rostered across the week to ensure the effective delivery of care and support. In accordance with Regulation 23(1)(c) in order to 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, the Person in Charge has reviewed the risk register for the designated centre and they have added medications as a risk to the risk register. In order to ensure safety with the identified risks, the Registered Provider has ensured that immediate on site oversight in medication administration has been put in place and an action plan for the safe administration of medication has been devised with input from the Best Practice Committee, the Quality Department, Nursing Staff and Senior Management. A quarterly audit from the Person in Charge will take place following the completion of the action plan to ensure ongoing oversight of the risks associated with medication administration and management. Management of the local service area and nursing staff will also continue to carry out unannounced medication supervision on a regular basis to ensure safety in this area.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In accordance with Regulation 26(2) to 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, the Person in Charge has reviewed the designated centre's risk register and updated it to include medication administration. The person in charge has also developed an immediate action plan for the safe administration of medications, to include immediate management supervision of administration from the day of the inspection. In relation to identified areas of improvement with falls risks, a full multi-disciplinary review of each resident's assessment of falls risks is scheduled for 22nd January 2025.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
In accordance with Regulation 29 (4)(b) in order to 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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident, the Registered Provider has ensured that immediate on site management supervision of administration was in place from the day of the inspection. The Person in Charge, with input from the Best Practice Committee, the Quality Department, Nursing Staff and Senior Management has devised a responsive Medication Action Plan that focuses on medication practices from pharmacy, administration, documentation and auditing. Ongoing supervision from management initially at each administration occurred for three weeks after the inspection to ensure that practices in medication administration were improved. This supervision is continuing on an ad-hoc unannounced basis and will continue to do so. Additionally, competency assessments have been completed with all staff by one of the organisation's medication trainers. Medication administration is being assigned to one person on each shift with a second person identified to supervise their administration and deputise for them should the need arise each day. There has been an immediate improvement in practice and a reduction in errors. In relation to identified medication prescription issues, these have been rectified and support has been provided by the GP and pharmacy. For one particular medication, a protocol is being reviewed by the prescribing consultant and will be available in the first week of January 2025. In relation to the dispensing and receipt of medications into the Designated Centre, this is now being completed by two staff and documentation for each resident's medications has been devised to identify each medication. The pharmacist will also be providing descriptions with each prescription and staff are ensuring this is in place each time. Nursing staff within the Designated Centre are also supporting all staff to upskill themselves in relation to the effective use of the monthly medication audits. The team leader or senior person on duty each weekend is carrying out an audit of medication practices and these are being overseen by the Person in Charge.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	28/02/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	31/01/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery	Not Compliant	Orange	28/02/2025

	of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	27/11/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/01/2025
Regulation 29(4)(b)	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 medicine which is prescribed is	Not Compliant	Red	27/11/2024

	administered as prescribed to the resident for whom it is prescribed and to no other resident.			