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:	Rusheen House
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Announced
Date of inspection:	18 November 2024
Centre ID:	OSV-0005780
Fieldwork ID:	MON-0036700

About the designated centre

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

Rusheen House is a community residential service providing care and support to four adults with an intellectual disability who have complex health and behaviour support needs. The service is located in a rural setting within driving distance to a busy town. The centre comprises a two-storey house with four bedrooms and several communal rooms which the residents share. Residents at Rusheen House are supported by a staff team, which includes both nursing and social care staff. The staff support provided is based on the needs and abilities of the residents and included a waking night support arrangement.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Monday 18 November 2024	09:30hrs to 17:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection to monitor and review the arrangements that the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and to inform a registration renewal application. The inspection was completed over one day and during this time the inspector met with the residents, family members and staff. From what the inspector observed, it was clear that the residents living at this designated centre were enjoying a good quality life where they were supported to spend time with their families, to participate in the running of their home and be involved in their communities. However, improvements were required to guidance provided in relation to risk management and positive behaviour support. In addition, improvements to the garden area of the premises would ensure that a safe space for residents was provided.

On arrival at the centre, the inspector met with the person in charge who commenced employment at this centre on 23 September 2024. Later that evening, they were joined by the registered provider representative.

There were two residents at home that morning. The inspector spent time with them in their living room where they were watching television while supported by two staff. Conversations held were short due to their communication abilities, however, it was clear that the staff understood the residents well and could act as their communication partner. Later, the third resident returned to the centre from their home. They were presented as content as they entered their home. They were observed walking from room to room while greeting other residents and staff. Later, all three residents left their house in the transport provided as they had plans for the day.

The inspector met with the resident and their family in the sitting room. The role of the inspector was discussed and information about the inspection was provided. When asked, they said that they were very happy with the service provided at Rusheen House. They said that staff were very good, their family member was very happy and that it was similar to being at home. They spoke about the feedback questionnaires circulated by the provider which they found useful. In addition, the person in charge gave the inspector four easy-to-read resident surveys which were used to gather feedback from other residents in advance of the inspection. These were completed with staff support and outlined positive feedback about the premises provided, their comfortable bedrooms, weekly residents' meetings and having choice and privacy.

A walk around of the centre found that it was a bright, welcoming and spacious home. The 'nice to meet you' inspection information document was displayed for residents so that they were aware of the inspection taking place. The kitchen and living room were well equipped and it was clear that this was a space where residents like to relax while being close to what was happening. Visual menu plans

were displayed on the wall. When asked, residents told the inspector that they enjoyed the food provided. Some residents agreed to the inspector visiting their bedrooms which were personally decorated, warm and cosy. All residents had the use of their own bathroom and shower facilities. In addition, this house provided a range of places for residents to relax and to host visitors. There was a sitting room at the front of the house, a second sitting room for a resident upstairs and an outdoor space known as the 'men's' shed' in the back garden. This was warm, had comfortable chairs, a television and exercise equipment. Staff said it was a popular space for activity and relaxation.

Staff spoken with said that residents enjoyed a good quality of life since moving to their community-based home. When asked, they said that they were aware of the importance of human rights and had training provided. They spoke about respect, offering choice and ensuring that residents were treated in a manner that was equal to any adult. The staff nurse on duty spoke about the Assisted Decision-Making (Capacity) Act 2015 which showed that they had a good understanding of how to support residents to make decisions.

Overall, this inspection found that residents living at Rusheen House were provided with a person-centred service where their choices were respected. The premises provided was suitable for their assessed needs. Residents were actively involved in their communities in line with their individual preferences. Some attended structured day services while others participated in home-based activities. Residents and their families expressed satisfaction with the service provided through conversations held and questionnaires provided. The staff team consistent and this had a positive impact on the quality of the service provided. Improvements in risk management and behaviour support systems would further add to the quality of the service.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affects the quality and safety of the service provided.

Capacity and capability

The inspector found that the provider had the capacity and capability to provide a person-centred service. There was a recent change in the leadership arrangement and this was reported to be working well. Improvements in relation to risk management, positive behaviour support and the external premises will be expanded on in the next section of this report.

As outlined, this was a registration renewal inspection and the provider's insurance arrangements were reviewed. The insurance contract was up to date and met with requirements. The statement of purpose was available to read in the centre and it was found to be an accurate reflection of the service provided. The policies and

procedures required under Schedule 5 of the regulation were prepared in writing and were stored in the centre. A sample reviewed found that they were up to date.

The management structure consisted of a person in charge who reported to the provider representative. The person in charge had responsibility for the governance and oversight of two designated centres. As outlined, they were new to this centre and they told the inspector that they were provided with good support. They worked full time and had the qualifications, skills and experience necessary to manage the designated centre and for the requirements of the role.

Staffing arrangements were reviewed as part of the inspection. A planned and actual roster was available and it provided an accurate account of the staff present at the time of inspection. The provider ensured that the number and skill-mix of staff met with the assessed needs of residents. When addition staff were required, an arrangement was in place to ensure that they were familiar with the needs of residents.

Staff had access to appropriate training, including refresher training, as part of a continuous professional development programme. A staff training matrix was maintained which included details of the training modules attended. All those reviewed were up to date. A formal schedule of staff supervision and performance management was in place, with meetings taking place in accordance with the provider's policy.

A review of governance arrangements found that there was a clear management structure in place. The centre was adequately resourced and the premises was of a high standard. Team meetings were taking place on a regular basis and the minutes were available for review. In addition, the inspector completed a review of incidents occurring and found that they were reported to the Chief Inspector of Social Services in a timely manner and in accordance with the requirements of the regulation.

Overall, the inspector found that the recent change in leadership did not impact on the quality of the service provided. The staff employed in the centre were trained and consistent. While there were systems in place to underpin the safe delivery of the service, some of these required review. This will be expanded on under section two of this report.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted an application for renewal of the registration of the designated centre to the Chief Inspector of Social Services which included the information set out in Schedule 2. Where updated information was required, this was submitted in line with the timeframes provided.

Judgment: Compliant

Regulation 14: Persons in charge

The substantive person in charge was on statutory leave at the time of inspection. The provider had recruited a new person in charge who was employed full-time and had responsibility for Rusheen House and one other designated centre. A compliance assessment completed in October 2024 found that they had the appropriate qualifications, skills and experience and met with the requirements of the regulation.

Judgment: Compliant

Regulation 15: Staffing

The provider ensured that the staffing arrangements at Rusheen House met with the assessed needs of the residents.

For example, the residents living at this designated centre had a range of high support needs which included support with behaviours of concern. A high level of consistent care and support was recommended by their multi-disciplinary team and the inspector found that this was provided. There were four staff on duty during the day and an additional twilight shift in the evenings. In addition, two waking night staff were provided at night time.

The provider and the person in charge had arrangements in place to respond to staff shortages. This included the allocation of additional hours to the core staff team or the employment of familiar agency staff.

This was a nurse-led service and nursing care was provided in line with the statement of purpose and the assessed needs of the residents.

The inspector reviewed a sample planned and actual roster from 1 October 2024 to the date of inspection (18 November 2024) and found that it provided an accurate reflection of the staff on duty at the time of inspection. The roster was well maintained and the name and role of staff employed were clearly documented. Some improvements were required with clarity of leave arrangements which were reviewed by the person in charge at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a range of training and development options which were appropriate to the needs of the residents, the service provided and the role held.

The provider had a training matrix which was maintained by the person in charge and documented training completed and training due.

The inspector reviewed a sample of mandatory modules which included fire safety, positive behaviour support and safeguarding vulnerable adults which all staff had completed.

In addition, staff were provided with training options that were relevant to the assessed needs of residents at Rusheen House. This include moving and handling training for a resident with decline in their mobility.

Furthermore, staff were provided with training in human rights. Those spoken with were aware of the importance of respecting residents' rights, offering choice and ensuring that they were treating in a manner that was equal to their peers. The staff nurse on duty spoke about the Assisted Decision-Making (Capacity) Act 2015 which showed that they had a good understanding of how to support residents to make decisions.

Staff had access to a formal supervision programme as part of their professional development. The person in charge had a schedule for performance achievement meetings and meetings were completed in line with the schedule.

Judgment: Compliant

Regulation 22: Insurance

The provider had a contract of insurance in place that met with the requirements of the regulation.

Judgment: Compliant

Regulation 23: Governance and management

There was a change to the management structure at the centre recently which was notified to the Chief Inspector of Social Services in line with requirements. The new person in charge was settling into their role and the inspector found that they were familiar with the residents and the documentation systems in the centre. The

management structure was clearly defined and staff were aware of who to report to if required.

The centre was had sufficient resources to meet the assessed needs of the residents. Their home was well equipped, two transport options were provided and staffing levels were satisfactory. Team meeting were taking place regularly a sample of the minutes taken were reviewed (22 August 2024 and 25 October 2024). Weekly residents meetings were held which the residents were reported to find useful.

The provider had a range of audits which were used to ensure good oversight of the services. The annual review of care and support was completed on 19 January 2024 and the six monthly provider-led audit was completed on 29 October 2024. The person in charge had a quality improvement plan which documented the actions from these audits and ensured that there was planned follow up.

Improved oversight of the guidance used for restrictive practices and risk management processes would strengthen the governance arrangements in place. These matters are reported under the specific regulations in this report.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which was reviewed and updated on 28 October 2024. It provided an accurate reflection of the operation of the service and included the changes in the governance and management arrangements at the centre.

Judgment: Compliant

Regulation 30: Volunteers

A review of this regulation found that volunteers were not involved in the centre at the time of inspection and there was no plan for this to happen. However, the provider assured the inspector that if this were the case in the future that a policy was in place to ensure safe practice.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed the incidents which occurred at the centre from 1 January 2024 to the date of inspection. They found that if required, notifications were submitted to the Chief Inspector of Social Services in line with the requirements of the regulation.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had written policies and procedures which met with the requirements of Schedule 5 of the regulation. The inspector requested a sample of the policies including safeguarding, provision of intimate care, provision of behaviour support, the visitors' policy, staffing training and development policy, risk management policy and health and safety policy. They were readily available and those reviewed were up to date.

Judgment: Compliant

Quality and safety

This inspection found that residents living in Rusheen House were provided with person-centred care and support by an experienced staff team. Residents living here were a mixed age group, however, the premises provided was spacious and designed so that it was suitable for all. Evidence was provided that people were supported as they aged and plans were put in place to ensure that they could remain in their home. However, improvements were required with some areas in the garden to ensure that they were safe. In addition, a review of risk management and positive behaviour support arrangements was required which will be expanded on below.

Residents living at Rusheen House had good contact with their family and friends and were active members of their communities. Some attended structured day services while others enjoyed home-based activity options which were more suitable for their age and ability. Visitors were welcomed to Rusheen House and there were a range of areas provided for comfort and privacy. Some improvements to the garden area of the premises would improve the safety of that area and this will be expanded on under the regulation below.

Residents that required support with behaviours of concern had access to behaviour support specialists and had behaviour support plans. The provider had a policy on positive behaviour support and staff had training was up to date. However, a review

of restrictive practices relating to chemical restraint was required to ensure that the guidance for staff was clear and unambiguous.

The provider had safeguarding systems in place to guide staff and to ensure that residents are protected and safe from harm. The provider's safeguarding policy was up to date, staff were training in safeguarding and there were no open safeguarding concerns at the time of inspection.

The provider had systems in place to ensure risks were identified, assessed and managed within the centre. However, a review of some of the systems used was required to ensure that clear guidance for staff was provided. Fire risks were well management and there were systems and processes to detect, contain and extinguish fire. Residents had individual escape plans and fire drills were taking place in line with the provider's policy. Staff fire prevention training was up to date.

In summary, residents at this designated centre were provided with a good quality service by an experienced staff team. Although there were changes to the governance arrangements recently, this did not appear to impact on the quality of the service provided. Further work on risk management measures, use of restrictive practices and some improvements to the garden of the premises would add to the good level of compliance found on this inspection.

Regulation 11: Visits

Residents at Rusheen House had maintained good relationships with their families and this was supported by the provider and the staff team.

Visitors were welcome in the centre and were encouraged to participate in the resident's life if in line with the resident's wishes.

Suitable visiting facilities were provided. There were three living rooms in the main house and a relaxation room in the garden. This meant that residents could receive visitors in a private area that was not their bedroom.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to connect with their family and friends and to participate in their local community.

Staff spoken with told the inspector that the quality of the residents' lives had improved over the years since they moved from a congregated setting to a community home. They spoke about the fact that their food was cooked in their

own kitchen and that they could do their own laundry. In addition, they said that access to two vehicles meant that they could actively participate in their community if they choose to do so.

All residents had access to facilities for occupation and recreation in line with their individual needs. Options included structured day services and home-based recreation programmes.

Home-based activities were provided in line with individual interests. For example, one resident enjoyed recycling glass items at the community recycle centre. This was linked with a proactive strategy in their behaviour support plan which meant that routines were adapted into meaningful activity.

Judgment: Compliant

Regulation 17: Premises

The provider ensured that the house provided met with assessed needs of the residents. It was of sound construction, kept in a good state of repair and was clean and suitably decorated.

Improvements were evident since the last inspection. These included repairs to the kitchen, flooring and painting and decorating.

However, some improvements were required externally which are outlined below.

- A garden shed was provided for storage. It was in poor repair with broken panels and a broken window. This required review.
- Perimeter fencing was provided around the garden. In the main, it was in a good state of repair, however, there was a gap in the fencing at the rear of the property where the gate had fallen down. This required repair.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had risk management systems in place for the assessment, management and review of risk. These included a risk management policy which was up to date and service level and centre level safety statements.

The inspector completed a review of the risks associated with a resident with declining mobility. This found that incidents such as slips, trips, falls and bruising were identified promptly and recorded on the provider's incident management form.

Incidents were monitored and reviewed at service level on a monthly basis by the incident review group.

At centre level, the residents risk assessment was reviewed on 12 October 2024 and a falls assessment was updated on 6 November 2024. Control measures included the input of the multi-disciplinary team which ensured a co-ordinated response to the risk. The resident's medicines were reviewed by their general practitioner (GP) and occupational therapy and physiotherapy support was ongoing.

However, a review of some risk management measures was required to ensure that guidance for staff was clear. For example,

- A resident with a history of making allegations towards staff and peers had a risk assessment and control measures for staff to follow. However, signposting to three different methods of documentation was provided. This included on a specific complaints form, on an accusation form or in the resident's care plan. This meant that there was a lack of clarity on how to manage the risk which could lead to issues with risk tracking and trending.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had fire safety management systems in place including arrangements to detect, contain and extinguish fires and to evacuate the premises. The fire prevention policy was up to date and all staff had mandatory and refresher training completed.

Residents were provided with person emergency evacuation plans and staff employed were familiar with the building and with the escape routes to follow if required.

In addition, residents participated in fire safety training and received certificates of achievement on completion. This meant that there was inclusive response to fire safety and residents were included.

Fire drills were competed on a regular basis, and both daytime and night-time scenarios were used. Safety checks were taking place regularly and the information was recorded.

Judgment: Compliant

Regulation 7: Positive behavioural support

All residents living at Rusheen House had access to behaviour support specialists and had behaviour support plans. The provider had a policy on positive behaviour support and staff had training was up to date. Staff spoken with were familiar with each resident's individual presentation, and aware of the occasions or actions that may trigger a behavioural reaction.

Restrictive practices were used in this centre. These included environmental safety restraints such as door locks and physical restraints such as safety belts which were reviewed by the occupational therapist. The provider had a human rights committee who reviewed the use of restraint on a regular basis.

However, chemical restraint was prescribed for use in this centre and the inspector found that the arrangements in place required review as follows,

- Not all chemical restraint was used in line with guidance. For example, a resident who experienced a time of distress in August 2024 had PRN (as needed) medicines administered on 19 occasions. During the same month they were prescribed psychotropic medicine by their GP for a two week period. While, a PRN protocol for this medicine was available, it was not updated to reflect the change in daily administration during the two week period.
- In addition, not all PRN (as needed) medicines were administered at the time outlined in the protocol. For example, on two sample occasions (22 August 2024 and 23 August 2024) it was administered earlier than recommended.
- Furthermore, a review of the use of chemical restraint as a last resort was required. For example, chemical restraint was administered in August 2024 when a resident was reported to become anxious in their bedroom. A review of their behaviour support strategies recommended distracting the resident and removing them from the immediate environment as a de-escalation technique in the first instance. Evidence was not provided to show that this occurred.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had safeguarding systems in place to guide staff and to ensure that residents are protected and safe from harm.

There were no open safeguarding concerns at the time of inspection. If a safeguarding concerns arose, the inspector found that the response was prompt and a plan was put in place which was in line with local and national safeguarding guidelines.

Residents were supported to understand safeguarding and how to protect themselves from abuse, through easy-to-read documents and discussion at residents' meetings. The safeguarding policy was up to date. Staff spoken with were aware of the identity of the designated officer and of what to do if required. Training in safeguarding was provided and a review of the training matrix found that all staff had completed this training.
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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Rusheen House OSV-0005780

Inspection ID: MON-0036700

Date of inspection: 18/11/2024

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The PIC has agreed a plan for the repair of the damaged shed and damaged fencing with the Maintenance Manager which will be completed by 15/01/25 • This planned work has been included on the centres QIP.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Risk assessments are currently being reviewed by the PIC and CNS in Behaviors to ensure clarity regarding the management of the risk and the correct recording form for completion. These will be reviewed on a regular basis. • An Accusations Protocol is in place which is followed when the resident has made an allegation. The protocol outlines the procedures for investigating the allegations and follow up procedures if required. • Any allegation which is deemed to have potential for safeguarding implications is screened as per the HSE Safeguarding Policy and HR Procedures. This will be completed by: 15/01/2025	

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC will ensure that:
• All PRN protocols are reviewed in the event that the regular prescription has been adjusted with the same medication to include the maximum daily dosage.
• PRN protocols will be signed by the GP/Consultant when the protocol has been amended to include maximum does within a 24 hour period.
• The HSE Medication policy is in place which outlines the procedures regarding PRN administration and Protocols.
• All medication kardex will be reviewed by the relevant prescriber to direct the timeline for administration of PRN medications. This timeline will be noted in the updated PRN protocol and signed by the prescriber as outlined in the HSE Medication Management Policy (2023).
• PRN administration Rationale Form will record the rationale for administrating medication and strategies that have been used prior to the administration of PRN medication. PRN which has been prescribed on a regular regimen for a period of time will be noted on this recording form. Staff administering medication will make note of the previous time that the medication has been administered to ensure that medication is administered within the advised time frame.
• Six monthly audits are completed providing oversight and monitoring of the administration of PRN medication.
• Prescribers are contacted should PRN medications have been administered on three occasions within a 7 day period for advice.
• Positive Behavior Support Plan is reviewed to include strategies for low arousal techniques during the night for one resident to reduce the risk of disturbance to other residents.

This will be completed by the 15/01/2025.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	15/01/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	15/01/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to	Substantially Compliant	Yellow	15/01/2025

	respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	15/01/2025
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	15/01/2025