Inverclyde council

AGENDA ITEM NO: 7

Report To:	**Social Work & Social Care Scrutiny Panel**	**Date:**	**27 August 2024**
Report By:	**Kate Rocks, Chief Officer, Inverclyde HSCP**	**Report No:**	**SWSCSP/24/2024/AB**
Contact Officer:	**Alan Best, Head of Health & Community Care, Inverclyde HSCP**	**Contact No:**	**01475 715949**
Subject:	**Supported Living Service Care Inspectorate Inspection - 8 May 2024**		

1.0 PURPOSE AND SUMMARY

1.1 ☐For Decision ☒For Information/Noting

1.2 This report provides an update to the Social Work and Social Care Scrutiny Panel on the recent inspection of Inverclyde's Supported Living Team and Care at Home Service (for Learning Disability) carried out by the Care Inspectorate.

1.3 The Supported Living Team and Care at Home Service for adults with Learning Disability had an unannounced inspection on 8 May 2024 which was carried out over 4 days concluding on the 15 May. Inspectors spent most of their visit at James Watt Court on Holmscroft Street but also met with Supported Living (outreach) staff based at the Fitzgerald Centre.

The inspection consisted of one inspector and one senior inspector to carry out observations of staff at James Watt Court, discuss the quality of service with service users and to ensure that the appropriate documents were within the service user Support Plan files.

The inspectors spoke with eleven people using the service and had contact with eight of their relatives, spoke with fourteen staff and management and looked at documents including the files of three tenants.

The Service received a draft inspection report on 5th June to view and agree to the content. The Inspection report was published on the Care Inspectorate website on the 28th of June 2024.

1.4 Key messages from the inspection:

- Management and staff were very good at developing meaningful relationships with people.
- People were supported to participate in a wide range of community activities.
- Management and staff have developed relationships with external health professionals, enhancing the health and wellbeing of people.
- Support plans and risk assessments did not always guide staff on people's current support needs.
- The management team require to improve systems around medication support and recording.
- Quality audits were not used to good effect and therefore did not inform improvement.

The Care Inspectorate use a six-point scale where 1 is unsatisfactory and 6 is excellent. The gradings received were:

How well do we support people's wellbeing	3 (adequate)
How good is our leadership	3 (adequate)
How good is our staff team	3 (adequate)
How well is our care and support planned	3 (adequate)

Within the key area 'how well do we support people's wellbeing' there are sections where the service was graded 4 (good); these areas are: people experience compassion, dignity and respect and people get the most out of life.

1.5 Inverclyde HSCP Chief Officer has recently visited staff and service users at the Supported Living service and was reassured by the high quality of supportive relationships displayed by staff and service users. The Chief officer directly met with service users and was encouraged by the service user's experiences in the support in achieving independent living in their local community.

2.0 RECOMMENDATIONS

2.1 The Social Work and Social Care Scrutiny Panel is asked to note the recent Care Inspectorate inspection of the Supported Living Team and Care at Home (Adult Learning Disability) services.

2.2 The Social Work and Social Care Scrutiny Panel is asked to note the contents of the improvement plan and the improvement actions that will be completed within the agreed timescales.

Kate Rocks
Chief Officer
Inverclyde HSCP

3.0 BACKGROUND AND CONTEXT

3.1 Inverclyde Learning Disability Support and Care at Home Service enable people with learning disabilities to live in their own homes throughout Inverclyde. The service is operated on a 24/7 basis. There are three elements within the service, including two supported living services and a dispersed service supporting people in their individual tenancies across the local area. At the time of the inspection 23 people were supported. The registered manager was supported by a senior co-ordinator, four senior support workers and a team of social support workers.

3.2 The Health and Care Staffing (Scotland Act) 2019 which was paused during the Covid-19 pandemic was enacted on the 1st April 2024. The guiding principles of the Act states staffing for health care and care services is to be arranged while taking account of the particular needs, abilities, characteristics and circumstances of different service users and being open with staff and service users about decisions on staffing. The Act also places a duty on care service providers to ensure appropriate staffing.

4.0 PROPOSALS

4.1 The Improvement Plan that has been developed is robust and can be viewed at **Appendix 1.**

Since the inspection was carried out, the service has been working on their Improvement Plan, progressing all the actions following recommendations made by the Care Inspectorate and these actions are on track to meet the timeline set by the Care Inspectorate.

There will also be an easy-read version of the improvement plan produced so all tenants in the service can participate in the completion of the action plan.

The Chief Social Work Officer and Head of Health & Community Care will meet on a regular basis to review the progress of the actions to meet the recommendations with regard to:

Medication - Improvements to be made by 2nd July ’24 – Actioned

- Assessed medication levels for each tenant is detailed, accurate and directly linked to need and support requirements.
- Medication records for each person are accurate, up to date and clearly reflect the medication prescribed and administered (including creams).

Staffing - Improvements to be made by 2nd July ’24 – Actioned

- Staffing assessment and planning is transparent.
- Staff deployment and skills mix are based on people's outcomes and needs.

Restrictive Practices - Improvements to be made by 26th November ‘24

- Restrictions are subject to regular review, to assess effectiveness and any changes required.
- Legal powers in place, are sufficient for any restrictive practices implemented.

Quality Assurance - Improvements to be made by 26th November ‘24

- The registered manager utilising a quality assurance framework to ensure complete oversight of the service and ongoing key activities, including information in relation to legal powers.

- Quality assurance systems continually evaluate and monitor service provision to inform improvement and development of the service.

Support Planning - Improvements to be made by 26th November '24

- Each person has a detailed support plan which reflects a person centred and outcome focused approach directing staff on how to meet people's care and support needs.

- Support plans contain accurate and up to date individualised risk assessments, which direct staff on current or potential risks and risk management strategies to minimise risks identified.

5.0 IMPLICATIONS

5.1 The table below shows whether risks and implications apply if the recommendation(s) is(are) agreed:

SUBJECT	YES	NO
Financial		x
Legal/Risk		x
Human Resources		x
Strategic (Partnership Plan/Council Plan)		x
Equalities, Fairer Scotland Duty & Children/Young People's Rights & Wellbeing		x
Environmental & Sustainability		x
Data Protection		x

5.2 **Finance**

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A					

5.3 **Legal/Risk**

None. The service still meets the level of grading where social work can place new tenants in the service.

5.4 **Human Resources**

See above – one Senior Coordinator post to be filled. Support with SSSC and other training requirements of staff to be supported.

5.5 **Strategic**

None.

5.6 **Equalities, Fairer Scotland Duty & Children/Young People**

None. The service exists to increase housing and support options for adults affected by Learning Disabilities.

(a) Equalities

This report has been considered under the Corporate Equalities Impact Assessment (EqIA) process with the following outcome:

	YES – Assessed as relevant and an EqIA is required.
x	NO – This report does not introduce a new policy, function or strategy or recommend a substantive change to an existing policy, function or strategy. Therefore, assessed as not relevant and no EqIA is required.

(b) Fairer Scotland Duty

Has there been active consideration of how this report's recommendations reduce inequalities of outcome?

	YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
x	NO – Assessed as not relevant under the Fairer Scotland Duty.

(c) Children and Young People

Has a Children's Rights and Wellbeing Impact Assessment been carried out?

	YES – Assessed as relevant and a CRWIA is required.
x	NO – Assessed as not relevant as this report does not involve a new policy, function or strategy or recommends a substantive change to an existing policy, function or strategy which will have an impact on children's rights.

5.7 **Environmental/Sustainability**

Has a Strategic Environmental Assessment been carried out?

	YES – assessed as relevant and a Strategic Environmental Assessment is required.
x	NO – This report does not propose or seek approval for a plan, policy, programme, strategy or document which is like to have significant environmental effects, if implemented.

5.8 **Data Protection**

Has a Data Protection Impact Assessment been carried out?

	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals.
x	NO – Assessed as not relevant as this report does not involve data processing which may result in a high risk to the rights and freedoms of individuals. The proposal to import spreadsheets of SSSC registration is additional data, but this information is already available on a public website.

6.0 CONSULTATION

6.1 All tenants and families of the tenants have been contacted since the Inspection Report was published and invited to come in and participate in the Improvement Plan.

7.0 BACKGROUND PAPERS

7.1 Improvement Plan – attached.

Medication

Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?	**RAG**
Assessed medication levels for each tenant is detailed, accurate and directly linked to need and support requirements.	We will review each tenant's current medication, seek further advice from GP and complete a medication assessment form for each tenant which will clearly identify support requirements.	No later than 2nd July 2024	**Registered Manager** – monitoring completion **Senior Coordinator & Senior Support Workers** – Supporting completion. **Keyworkers** – Discussing with GP's and completing medication assessment paperwork	**Completed** Keyworkers have contacted GPs. All medication levels are now accurate on MAR. Medication assessment forms have been completed with full participation of tenants with their preferences being taken into account.	**GREEN**
Medication records for each person are accurate, up to date and clearly reflect the medication prescribed and administered (including creams).	We will introduce an audit for all medication records for all tenants, we will review medications and seek further advice from GP and Community Pharmacist lead regarding administration of creams, including times of administration	No later than 2nd July 2024	**Keyworkers** – Contact GP to ensure that prescribing labels and MAR sheet labels reflect the medication requirements, including creams. **Registered Manager, Senior Coordinator and Senior Support Workers** – Develop and introduce a robust medication audit system that is reflected within the medication policy for the service, with advice from M Maskrey, Lead Pharmacist HSCP.	**Completed** Medication Audit process has commenced. One outcome that has been highlighted is excess medication which has been returned to pharmacy. Thereafter monthly audits carried out for each tenant by seniors/senior coordinator. Registered Manager will complete a further audit twice yearly to quality assure process.	**GREEN**

Appendix 1

Improvement Plan - Requirements & Recommendations

Detailed as required protocols are in place for each medication that has been prescribed "as and when required". They should include information on when it has to be given, intended outcome and thresholds for further action.	'As and when' will be implemented for all tenants that have 'as and when required' medications prescribed. The protocol where appropriate have been agreed by the GP or tenant's legal guardian.	No later than 2nd July 2024	**Registered Manager, Senior Coordinator and Senior Support Workers** – To review all as and when required medications and support keyworkers to implement protocols. **Keyworkers** – To implement 'as and when required' protocols and where possible, get sign off from GP.	**Completed** All as and when required medication has been reviewed, surplus medications have been returned to pharmacy and return slips have been signed. All 'as and when required' medications have a protocol clearly detailing when it has to be given, the intended outcome and thresholds for further action. Protocols, where possible, have been signed and stamped by individuals GP's.	**GREEN**
Staff responsible for supporting people with medication clearly understand the process of and importance of recording and administering medication.	We will discuss with staff at each team meeting, and this has become a standard agenda item at 1:1 supervision. We will utilise the existing HSCP medication training for staff team and senior managers and manager.	No later than 2nd July 2024 No later than 2nd July to get dates confirmed.	**Registered Manager, Senior Coordinator and Senior Support Workers –** Add to agenda for each staff meeting and add to 1:1 supervision agenda. **Registered Manager–** Arrange for further training to be delivered.	**Completed** Medication is a standard agenda item at team meetings. Our audit and quality assurance will incorporate staff observations on a twice-yearly basis. Training dates have been scheduled for all staff, training to be delivered on 22nd, 29th and 31st July 2024. Training is being delivered by HSCP Interface Pharmacist and is aligned to	**GREEN**

				overarching HSCP Adult Medication Support Policy.	
Medication audits are regular and effective; identifying gaps and actions required to improve recording and practice in line with current organisational policy and good practice guidance.	We will develop and implement a robust medication audit system that is in line with current good practice guidance.	No later than 2nd July 2024	**Registered Manager, Senior Coordinator and Senior Support Workers** – Develop and introduce a robust medication audit system that is reflected within the medication policy for the service. **Registered Manager, Senior Coordinator and Senior Support Workers –** Review current medication procedures to ensure that they include the requirements for tenants' medication audits.	**Completed** Medication audit has been developed, agreed and is now used for all tenants. This will be monitored via the overarching management audit tool. Medication policy has been reviewed to include the newly introduced medication audit system and will be reviewed twice yearly within the management audit tool.	**GREEN**

Staffing

Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?	**RAG**
Staffing assessment and planning is transparent.	Assessment of staffing requires continuous review of tenant's needs in partnership with care management. These will be	No later than 2nd July 2024	**Care Management** – To provide the service with the professionally assessed need for each tenant, staff team will	**Completed** Each tenant has assessed hours of support detailed on support plans on SWIFT.	**GREEN**

Staff deployment and skills mix are based on people's outcomes and needs.	discussed and agreed at 6 monthly reviews. We will ensure that these support hours are clearly detailed within tenant's support plans. Staffing assessment and the requirements are based on minimum safe care and support for each individual tenant. In order to ensure safe levels of staffing our staff assessment tool will be used alongside our mandatory training records, safe recruitment, robust induction, learning and development, supervision, competencies and skills mix.		support this to provide up to date, accurate information. **Registered Manager, Senior Coordinator and Senior Support Workers –** To add assessed support hours to review paperwork which will be discussed with care management at reviews.	Each tenant's support hours are detailed within their support plan. Support hours have been added to review template - further reviews are being arranged with Care Management input. Staffing assessment tool has been developed and compliments the support needs assessments. We ensure safe levels of staffing through our staff assessment tool is used alongside our mandatory training records, safe recruitment, robust induction, learning and development, supervision, competencies and skills mix. Professional competencies through observation concerning staff learning needs will also be utilised.	**GREEN**
Assessment and planning for tenants is based on current	Staffing assessment tool has been developed and used in conjunction with tenants' assessment of needs,	No later than 2nd July 2024 to Implement, 6	**LD Strategic Lead & Registered Manager** – Staffing assessment	**Completed** Assessed hours are detailed within tenant's support plans	**GREEN**

guidance and take into account a variety of meaningful measurements including people's assessed needs and support preferences. Staff deployment and skills mix will reflect gender preferences and needs of residents.	that will inform the preparation of the 6 weekly staff rotas. Where possible we will ensure that tenants preferences and choice around who is supporting them is taken into consideration. For example: Male support/Female support/Keyworker on shift working with key person. This practice will be aligned to '*Care Inspectorate Guidance for Providers on the assessment of staffing levels in premises-based care services' 2022.*	weekly reviews following this date when preparing staffing rota.		and support hours has been added as an agenda item on tenant's review template. Staffing assessment tool has been developed and used in conjunction with tenants needs assessment tool which informs the preparation of the 6 weekly staff rotas.	
	The supported living management team will review, 6 weekly, the assessed hours, any changing needs and staffing levels when developing the 6 weekly staffing rotas. This will allow the manager to undertake capacity planning and identify any increase required to meet changing need and discuss with care manager. To respond in a flexible and responsive way. We will ensure that assessed support hours are clearly detailed within tenant's support plans and are	No later than 2nd July 2024	**Registered Manager, Senior Coordinator and Senior Support Workers –** to use tenants needs assessment tool and staffing assessment tool when developing rotas.	We, where practical, ensure that tenants preferences and choice around who is supporting them is taken into consideration when rota planning. We discuss individual tenants changing need at team meetings and 1:1 supervision, these are then highlighted to the management team and at	**GREEN** **GREEN**

	reviewed 6 monthly or sooner if needs change.			reviews or sooner if required involving tenants and their families. Any changing needs are highlighted to the care management team.	
The service must ensure all staff are appropriately registered with their regulating body	SSSC Registrations will comply to the SSSC requirements regarding dual registration. We will implement a new process where the endorser (LP) will have access to SSSC site to view the service, the staff registered within the service and their renewal dates.	No later than 2nd July 2024 No later than 2nd July 2024 No later than 29th July 2024	**Service Manager, Registered Manager, Senior Coordinator -** To gather initial evidence of registration via SSSC. **Service Manager & Endorser with SSSC**– to extract data monthly from SSSC onto an excel document then forward to **Registered Manager, Senior Coordinator** **Registered Manager, Senior Coordinator** – To oversee monthly, notify staff when nearing declarations, end of registration date or conditions attached to registration. **Registered Manager, Senior Coordinator and Senior Support Workers** – To implement, review & update management audit tool.	**Completed** We have reviewed all our staffing lists against the SSSC register and where is there is requirements to review registration staff have been notified for this to be completed by Monday 1st July 2024. To date this has been completed. Registered manager and senior coordinator now have oversight of current workforce registrations on a monthly basis. The registered manager also overviews the endorser process and regularly discusses compliance for registration with the endorser, on a four-weekly oversight.	**GREEN**

				Staff are being reminded at team meetings and 1:1's about their duty to maintain and update their own registration as a contractual duty.	

Promoting Positive Behaviours (Restrictive Practices in Place)

Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?	**RAG**
Restrictions are subject to regular review, to assess effectiveness and any changes required	We will ensure that there is a clear focus on any restrictions, and this will be discussed at 6 monthly reviews. We will continue to focus on strength-based interventions that promote positive behaviors, whilst recognising the need for restrictions. We will involve the person, their legal guardian and any other professional involved in their care, such as social worker or MHO. We have commenced the implementation and that this will be	By 26 November 2024	**Registered Manager, Senior Coordinator and Senior Support Workers** – To ensure that restrictive practices are discussed at reviews with all parties	**Completed** Been added to the upcoming review template, recent reviews for 2 tenants that have restrictive practice in place are taking place in July 2024. Other reviews are being arranged.	**GREEN**

	a standard agenda item for tenant's reviews.				
Legal powers in place, are sufficient for any restrictive practices implemented.	We will review legal powers in place along with MHO to ensure that the service has legal powers to implement restrictive practice, whilst ensuring it is compliant with the principles of minimal intervention, consistent with AWI legislation. This has been implemented and will remain a standard agenda item for tenant's reviews. Progress of restrictions will be discussed openly and transparently, focusing on a strength-based decision making, at 6 monthly reviews with input from the individual, legal guardian, MHO, care manager and support team. Reference will be made to RightsRisksAndLimitsToFreedom March2021.pdf (mwcscot.org.uk)	By 26 November 2024	**Registered Manager, Senior Coordinator and Senior Support Workers** – To ensure that restrictive practices are discussed at reviews with all parties.	Been added to the upcoming review template for 2 tenants that have legal powers in place as of 1st July 2024.	**GREEN**
A promoting positive behaviours log (restrictive practice) is kept for the service detailing an overview of restrictions, dates of review, legal	A restrictive practice log will be developed for the service to include review dates and will be audited monthly.	By 26 November 2024	**Registered Manager** – To develop a restrictive practice log. **Registered Manager, Senior Coordinator -** To ensure the restrictive log is reviewed and updated.	Work is underway to develop this. Legal powers & AWI paperwork have been updated – 7th June '24	**GREEN**

powers in place with review dates.					
All staff have a clear understanding of the term restrictive practice and how these impact on support provision within the context of delivering person centred care.	We will deliver training for the team on restrictive practices and restraint. We will discuss this at team meetings and 1:1 supervision	By 26 November 2024	**Registered Manager, Senior Coordinator and Senior Support Workers** – Source training **Registered Manager, Senior Coordinator and Senior Support Workers –** Discuss at team meetings and 1:1's	MHO from CLDT has been approached to deliver appropriate training. We discuss restrictive practices at team meetings and 1:1 supervision. The HSCP training section is currently developing guidance which will be rolled out to the SLS staff Team and training provided along with information sessions for Tenants and representatives. LD Trauma informed Practice training currently being rolled out incrementally to staff, this will become part of the LD mandatory training programme. PPB training is mandatory for all staff, all staff have completed this in 2024.	**GREEN**

Quality Assurance & Audits

Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?	**RAG**
The registered manager utilising a quality assurance framework to ensure complete oversight of the service and ongoing key activities, including information in relation to legal powers.	We will implement a revised service audit tool that will be completed on a monthly basis by the registered manager and senior coordinator.	By 26 November 2024	**Registered Manager** – To revise audit tool and review monthly. **Senior Coordinator** – To have lead responsibility for the co-ordination of the audit and to carry this out in the absence of the registered manager.	Management audit tool is being revised and will be submitted to the CSWO for approval. On target for 29th July 2024.	**GREEN**
Quality assurance systems continually evaluate and monitor service provision to inform improvement and development of the service	Quality assurance processes will also involve tenants, staff, families and other professionals. The outputs from this activity will be reflected into the service development plan.	By 26 November 2024	**Registered Manager, Senior Coordinator** who will implement learning for service and advise CSWO of the improvements.	Focusing on best practice across the HSCP and learning from the other quality assurance processes, reporting mechanisms that are in situ or other HSCP registered services.	**GREEN**
Quality audits including care planning, finance and medication must be fit for purpose and used consistently across the service. Audits must be accurate, up to	All audits currently used will be reviewed and improvements put in place, if required, (direct observations, weekly medication counts, supervision, medication audits and reviewing) Audits will be used consistently across the service.	By 26 November 2024	**Registered Manager, Senior Coordinator and Senior Support Workers**	As above	**GREEN**

date and ensure they lead to the necessary action to achieve improvements without delay.					
Service management have a clear overview of staff SSSC registration and training including identified gaps.	Registration and renewal dates will feature within the quality assurance and audit tools. Training audits will be carried out and aligned to registration and renewal dates for registered workers. Individual training plans will be reviewed regularly at 1:1 supervision. Training needs analysis for the service will be shared at the HSCP training board that is chaired by the CSWO.	By 26 November 2024	**Service Manager** who is endorser for SSSC will be responsible for overseeing quality assurance and audit and advising CSWO of the outputs with a focus on improvement and learning.	Training needs analysis will be reported by the Service Manager to the CSWO, at the HSCP training board.	**GREEN**

Support Planning

Outcome What do we want to achieve?	**Actions** How are we going to do it?	**Timeframe** When do we want this to be completed or next reviewed?	**Person responsible** Who is doing each action or responsible for ensuring it gets completed?	**Where are we now?** What have we achieved, and what has prevented us from doing what we wanted?	**RAG**
Each person has a detailed support plan which reflects a	We will review tenants support plans via audit tool to ensure that they are outcome focused and person	By 26 November 2024	**Registered Manager, Social Workers, Senior Coordinator and Senior Support Workers**	Support plan audits have commenced, and seniors are supporting keyworkers to look	**GREEN**

person centred and outcome focused approach directing staff on how to meet people's care and support needs	centered. This will be carried out in conjunction with the allocated social worker. We are piloting new approaches to ensure that support planning is accessible, participative and improves meaningful engagement of residents, in developing and directing their support through the implementation of the 'I Plan It' app.			at support plans in detail with tenants, families and other professionals. Further discussion is required with allocated social workers to ensure wider participation. Funding for the new tablet computers and app has already been approved. We are currently training staff that will be involved in using them. Our residents have already participated in the initial use of the app and initial findings and feedback is very positive.	
Support plans contain accurate and up to date individualised risk assessments, which direct staff on current or potential risks and risk management strategies to minimise risks identified	We will audit support plans and risk assessments to ensure that any identified risk is well managed contemporaneous, and actions mitigate impact for residents. Risk assessments will be led by the allocated social worker and the service involving tenants, families, care manager, other health professionals and MHO if required.	By 26 November 2024	**Allocated Social Worker, Registered Manager, Senior Coordinator, Senior Support Workers and keyworkers**	To be progressed by deadline	
Future needs are anticipated, documented and reviewed.	Future needs planning will be a feature of the revised review processes and risk assessment. This will be considered a priority, in	By 26 November 2024	**Allocated Social Worker, Registered Manager, Senior Coordinator and Senior Support Workers**	To be progressed by deadline	

	recognition of the age, gender balance and likelihood of increased dependencies and support provision for residents. We will involve tenants and families.				
Support plans are regularly reviewed and updated with involvement from people, relatives and advocates.	We will work in partnership with the allocated social worker and continue to arrange reviews 6 monthly for tenants, ensuring that there is involvement from people, relatives and advocates (where appropriate).	By 26 November 2024	**Keyworkers with oversight by seniors and registered manager.**	Tenant's reviews are ongoing, 6 monthly, as current practice, however where there are significant changes or increase in complexity of needs and / or risk, regularity of reviews will reflect this.	
	New 'I Plan It' app will facilitate clear recording of people's outcomes and needs, including their individual preferences about how support is delivered.		**Registered Manager, Senior Coordinator** – to order the new software and get staff trained in how to use this with tenants	Funding for the 'I Plan It' app and tablet computers has been secured, along with funding for additional training to use this application.	
Detailed care reviews are undertaken regularly which reflects people's care needs and preferences	Regularity, timeliness and quality of reviews will be a feature of quality assurance audit processes.	By 26 November 2024	**Registered Manager, Senior Coordinator and Senior Support Workers**	Tenant's reviews continue as per 6 monthly guidance but will be more regular where there is significant changes or risks identified for the resident.	

Recommendations

Care Inspectorate Recommendation. 1

The safety and wellbeing of people and delivery of a quality service to people is ensured by good communication with people in relation to support provided. This will include provision of an individual schedule detailing who will be visiting, when and the support to be provided and this will be in a format that is accessible or an individual's communication needs.

Inverclyde HSCP's Response:

Please refer to actions and improvement detailed in the attached plan.

All actions will include an inclusive, and easy read/pictorial planner/schedule within each tenant flat (who wish this) detailing daily/weekly allocated staff member/activities and timings /appointments/meetings. This will be discussed with Key Worker and tenant on a weekly basis and any issues with who is delivering support explored and any conflict resolution implemented, and any changes agreed and actioned as appropriate.

It's important to be mindful of the day-to-day life of any adult where flexibility and choice and personal and organisational circumstances may require said schedule to change. Changes will also be communicated to tenants.

This information and communication may be incorporated into the Pilot 'I Plan 'App.

Care Inspectorate Recommendation. 2

Seeking opportunities to increase people's independence and

development of their daily living skills will continue to be good practice, and people will be enabled to make choices in their day to day lives, even

when there are restrictions in place to promote health and wellbeing

Improvement Plan - Requirements & Recommendations

Inverclyde HSCP's Response:

Please refer to actions and improvement detailed in the attached plan.

Restrictive practices will be used to respond to risk and safety and ensure that an individual leads a full and meaningful life. Practice will be trauma informed where all staff will be trained in this model of practice.

Tenants will be supported to understand, using appropriate and accessible communication, any decisions made about restrictions and interventions, and staff will use the least restrictive option for the shortest time possible if PPB plan is required.

Staff will continue to work hard to support all tenants, inclusive of those who have interventions, to develop connections and access activities within the local community to promote wellbeing and support good mental health.

People will continue to be supported with a range of health and wellbeing initiatives in support of positive

health. More planned health focussed projects for example, the "March into March" which promoted walking amongst staff and Tenants, will be planned and support will continue to be person centred and outcome focussed.

Staff will continue to access a range of health care professionals for advice and support when required as noted by the Care Inspectorate, building on the relationship with external professionals who advise that staff are responsive to their advice and guidance. This has a positive impact on people's health needs and of equal importance we are invested in proactively improving people's health.

Where there are restrictive practices in place, we will always start from a strength based and will be mindful of the minimal intervention threshold outlined in national policy and legislation. Our approach will be to promote positive behaviours understanding that trauma will be a contributory feature of risk and that all interventions are required to be proportionate whilst mitigating the necessity to implement restrictive practices in the tenant's lives. Where this is to be implemented this will be reviewed on a four weekly basis involving the resident, their family, and any other professionals who may have an informed view. This review will be led by service and the allocated social worker.

PPB Training is mandatory as is refresher training and observations around staff capability and competence and records kept of this.