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:	Roseville
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	20 & 21 November 2023
Centre ID:	OSV-0005738
Fieldwork ID:	MON-0033681

About the designated centre

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

Roseville designated centre provides community based living arrangements for up to three adult residents. Roseville is a modern and spacious property that provides residents with a high standard living environment which meets their assessed mobility and social care needs. Each resident has their own bedroom. This service provides supports for residents with severe to profound intellectual disabilities and complex needs. The provider identifies that residents living in this centre require high levels of support and has staffing arrangements in place to ensure residents needs are met. There is a full-time person in charge assigned to the centre, three staff during the day to support residents in having a full and active life and one waking night staff to ensure residents night time needs are met. The centre is resourced with one transport vehicle to support residents' community based activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 20 November 2023	12:30hrs to 17:30hrs	Sarah Mockler	Lead
Tuesday 21 November 2023	09:00hrs to 14:30hrs	Sarah Mockler	Lead
Monday 20 November 2023	12:00hrs to 17:00hrs	Louise Griffin	Support
Tuesday 21 November 2023	09:00hrs to 14:30hrs	Louise Griffin	Support

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision regarding the renewal of registration for this designated centre. The inspection took place over two days. Two other inspections were also carried out over that time frame in other centres operated by the registered provider. Some overarching findings in relation to the provider's oversight and governance and management arrangements were identified in all three centres inspected. In addition, improvements were required in financial safeguarding and the management of resident possessions. This report will outline the findings against this centre and the specific areas of improvement that were required to ensure the centre was operating at optimal levels of compliance.

In order to get a sense of what it was like to live in the home, the inspectors spent time observing care practices with residents, speaking with the staff team, and reviewing key documentation. The residents within this home primarily used gestures, facial expressions and vocalisations to communicate their immediate needs. All residents required significant support in all aspects of their care.

The centre was located in an urban area in Kilkenny. It comprises a small detached bungalow building located off a car park (the car park was not part of the designated centre). The centre had limited outdoor space available to residents due to its location. Inside the building were three bedrooms, a kitchen/sitting room, a visitors room, a small bathroom with a toilet and sink and a larger shared bathroom with showering facilities. The home was well kept and homely in presentation. Each bedroom was individualised with personal items and possessions on display. Some of the bedrooms were fitted with overhead hoists. Although the service was striving to promote good accessibility in the property, the size and layout of the property was not always conducive to this.

Throughout the course of this two day inspection, the inspectors met with all three residents that lived in the designated centre. On arrival at the centre two residents were sitting in the kitchen area. Music was playing in the background and a meal was being prepared by a staff member. The atmosphere was relaxed and the residents appeared comfortable overall in their home. One resident was not present as they were out into the local city with support from a staff member. They returned a little while later and staff chatted to the resident about their shopping trip. Another resident was being supported to have a cup of tea and staff were seen to interpret the residents communication responses in relation to this routine. Later in the day a resident appeared upset at times. Staff explained that they had a very poor nights sleep the night before and this was potentially impacting the resident's mood. Staff were seen to reassure and support the resident in a comforting manner. For example, staff were seen to sing preferred songs to the resident.

On the second day of inspection, on arrival at the centre two residents were up and getting ready for the day. One resident was in bed and their bedroom door was open. Although the home appeared warm and well presented there was a significant

malodour present. Staff reported that the malodour was caused by a nearby river that flowed near the home. Two staff were present at this time. Care and support was provided to ensure residents' needs were met but further consideration was required in relation to the communication aspect required. For example, staff were seen put perfume on a resident but not tell them or ask permission in relation to this. As all residents were visually impaired it was important that all aspects of care and support were communicated in an effective manner.

Access to the community and maintaining family links were a continued focus within the centre. Some residents were attending day service on a sessional basis. For example, one resident liked to go to a flower arranging class. They opted to take part in aspects of this class from a sensory perspective in line with their specific needs. Residents also enjoyed shopping trips in the city, visiting family and friends, getting their hair and nails done, and visiting cafés, reflexology and sound therapy. Holidays were in the process of being planed for one resident. There was one vehicle available to residents to access the community. Due to one resident's specific needs this vehicle was not always suitable and further assessments were being completed at the time of inspection around how this resident could best use the transport available. In the interim the resident used public transport to get access to their community when needed.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspector found that the centre did not have adequate governance and management systems and arrangements in place to ensure consistent monitoring of the quality of care being delivered. A number of improvements were required across some key regulations to ensure they met the minimum requirements of compliance.

There were clear lines of accountability and authority within the centre. On the day of inspection the person in charge was on unexpected leave and the team leader facilitated the inspection. Part of the team leaders responsibilities was to provide support to the person in charge and complete relevant delegated duties.

The inspectors found that there were deficits in oversight of residents healthcare-needs, staffing and staff training, financial oversight of residents monies and possessions and fire safety and safe evacuation procedures, which all needed to be addressed.

Prior to the inspection the provider submitted the annual review of service provision. This document was dated September 2022. No annual review of the quality of care had been completed in 2023 as required by the regulations. However, the provider had completed two six monthly unannounced audits of the centre. The provider had

identified that the oversight of actions from these audits required further improvement. Locally audits such as medication, finance, infection prevention and control were occurring a regular basis. However, oversight and management systems were failing to identify areas of improvement as found on inspection despite this auditing being in place. This is discussed in the relevant sections of the report.

The provider had determined that two staff during the day and one waking night staff was sufficient to meet the needs of the residents. The skill mix of staff present encompassed social care workers and health care assistants. From a review of a sample of rosters this level of staffing was present to support the residents. However, due to the specific assessed needs of residents, it was not clear if the resources present were sufficient to meet all the needs of residents at all times. As a number of residents required two to one care at times, residents community access required to be planned around this specific need.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted the required information to apply to the renewal of the registration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The statement of purpose described that nursing care was available to residents. On the day of inspection no nursing care was available in the centre.

While there was currently a deficit of two staff members in the designated centre, these gaps on the roster were covered by a consistent number of agency staff. However, the assessed needs of residents indicated that two residents required a minimum of two to one staffing for aspects of care. As only two staff were present at weekends the staffs ability to be responsive to residents' needs and wishes around community access could not be prioritised and had to be planned in advance. Further review of staffing levels were required to ensure they were in line with residents' specific needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The registered provider had a training matrix in place, and the inspector found that

all staff members had received mandatory training in safeguarding, food safety, fire safety, first aid, positive behaviour support, the safe administration of medication, managing eating, manual handling, and patient handling. Refresher training was available to staff members as needed.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured that records as specified in Schedules 2, 3, and 4 of the regulations were well maintained, were kept up-to-date and were suitably stored.

Judgment: Compliant

Regulation 22: Insurance

The provider had up-to-date insurance as per requirements of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider ensured there was a clearly defined governance structure within the centre which ensured that residents received a service that overall met their assessed needs.

The provider had not always ensured that there was always effective oversight systems in place in this designated centre. For example, there were deficits in oversight of residents healthcare-needs, financial oversight and fire safety. The relevant findings of the inspection are discussed in more detail in relation to each regulation below.Furthermore the annual review of quality of provision of care had not taken place within the required time frame as set out in the regulations. Audits and reviews that were occurring were not effective in identifying and driving quality improvement in key areas of compliance with regulation.

In addition, although records were maintained as set out in the Regulations, in general there was poor management of systems in relation to resident files. A number of resident files had outdated documents present, dated as far back as 2018. The systems in place to manage resident information required significant review to ensure the most up-to-date relevant information was present for each

resident.

Judgment: Not compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place. This statement of purpose contained much of the required information as set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of notifications submitted to the Office of the Chief Inspector occurred. For the most part all notifications were submitted as required

Judgment: Compliant

Regulation 34: Complaints procedure

There were policies and procedures in place in relation to complaints. Residents had access to an easy-to-read format of the complaints policies and procedures. A complaints officer was in place, and residents and their families were aware of how they could make a complaint. A complaints log was maintained, which outlined the nature of any complaints made, any actions taken, and the outcome of the complaint.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and care was overall provided in line with each resident's assessed needs. A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review residents' finances, risk documentation, fire safety documentation, and

documentation around healthcare-needs. A number of improvements were required in a number of areas to ensure they met the requirements of the regulations and that a quality and safe service was being delivered at all times.

The management of residents' finances required significant review from an organisational stand point. Due to the current systems in place, at times residents had limited access to their finances. In addition, the systems in place to ensure residents finances were safeguarded were inadequate. Although, these areas of improvement had been known to the provider, effective actions to address these issues were still required.

Practices in relation to residents' healthcare-needs required review. It was found that the documentation in place was not sufficient or comprehensive to guide staff practice in an effective manner. A detailed health history for each of the individuals was not in place and staff seemed unaware of a small number of practices and appointments that had occurred for some individuals. In addition, training around aspects of healthcare practices was not rolled out for all staff. Due to residents specific needs in this area this was considered as a significant risk and needed review.

Although the provider had taken some actions to protect residents in the event of an outbreak of fire within the designated centre, further measures were needed in this area to ensure that optimal safety requirements were met. A number of areas of improvement were identified on inspection including, provider level oversight, effective actions on foot of identified risks and up-to-date documentation.

Regulation 12: Personal possessions

The provider had identified that residents did not have access to bank accounts which was as a result of the systems in place within the organisation. Access to finances have to be requested through the main central office. As staff here were only available during office hours, access to resident monies after these hours was limited. Although the provider had identified the limitations of the types of accounts in place and had taken some action to try and rectify this, on the day of inspection the current practice remained in place.

In addition, the inspector reviewed the bank statements that were present and items that were allocated to residents. . Some residents had spent considerable amounts of money on personal items such as a television, tablet device and mobile phone. There was no record of these items on the residents' personal possession list. Some personal possession lists had not been updated since 2021. Effective management of residents' personal belongings was not occurring and staff had limited knowledge or references to what belonged to the residents within the centre.

Financial safeguards were very limited within the centre. Although the person in charge completed an audit on a monthly basis, the audit did not require the person in charge to cross reference receipts and expenditure with bank statements. There

were no audits in place in the centre that had completed this process within the last 12 months. Bank statements present were dated to June 2023. No up-to-date bank statements were available. It was unclear how finances were effectively audited.

In addition, it was unclear how residents input was sought in relation to certain spending that was occurring. For example a resident had spent money on presents and dry cleaning and there was insufficient evidence on how this decision was made. Residents required support in relation to all decisions around financial spending and there were insufficient systems in place to evidence how decisions were being made.

Judgment: Not compliant

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner and well maintained. The designated centre comprises a small detached bungalow located in an urban area in Kilkenny. All residents had their own bedrooms which were decorated to reflect their individual tastes with personal items on display. The requirements as set out in Schedule 6 of the regulations had been met.

Judgment: Compliant

Regulation 20: Information for residents

The required information was present in the residents guide. This guide was submitted as part of the renewal of registration process and was updated in line with any staff changes as required.

Judgment: Compliant

Regulation 26: Risk management procedures

There were a number of risk management systems in place in the centre with evidence of good oversight of ongoing risks. A centre-specific risk register was in place which identified a number of specific risks and had been reviewed on a regular basis. There were also individualised risk assessments in place which were also updated regularly to ensure risks were identified and assessed.

Overall risk control measures were found to be in place as set out in relevant risk assessments and the staff were aware of relevant risks within the centre. Risk

ratings were overall proportionate to the risks presents. Although a number of risks were identified in relation to fire safety and healthcare they are addressed under the relevant regulations.

Judgment: Compliant

Regulation 28: Fire precautions

This was an area that required continued focus and improvement. Although, the provider had taken some actions to ensure residents were safe in the event of an outbreak of a fire. Additional, measures were needed to provide assurances that all residents could be safely evacuated in the event of a fire.

The inspectors reviewed the latest fire drills that had occurred with the centre. The most recent fire drill had occurred at night and it was documented that it had taken 17 minutes and 22 seconds to evacuate. It was identified that the on-call system in place to help staff at night in the event of a fire had been ineffective, however limited actions had been taken on foot of this or to rectify the issues encountered. Further measures were needed to provide assurances that residents could be evacuated in a timely and safe manner in the event of an emergency.

In addition, the centre specific fire evacuation plan was inaccurate. It contained details around hoisting residents on a one-to-one basis with limited evidence on how this decision, or if a a suitably trained health and social care professional was consulted in relation to this. It did not contain details around the on-call system in place therefore unfamiliar staff would not know what centre to contact if a fire broke out at night and they were lone working.

Judgment: Not compliant

Regulation 6: Health care

For the most part residents were in receipt of a service that ensured the majority of residents' healthcare needs were being met. For example, each resident had access to their own General Practioner (GP). However, due to inaccurate documentation and a number of staff changes within the centre a comprehensive health history of individuals was not available. For example, on a resident's file the most recent healthcare documents which assessed residents' ongoing needs was dated May 2022. In this document it referenced an appointment with a health and social care professional and a specific recommendation around frequent health checks. Staff present were unaware if this appointment had taken place. In addition, the health checks were not occurring and staff could not find the information on when they were stopped or who directed that the checks were stopped. The residents

documented medical history document had not been updated since January 2022 and their hospital passport was not updated since December 2021.

Hospital discharge notes noted specific information around healthcare-associated infections. There was no other documentation on file, or staff knowledge in relation to this information.

Some residents had specific care needs and equipment that was utilised to ensure this need was met. There was no robust system in place to ensure staff had specific training in this area. For example, a staff member that commenced their role in July 2023 had on the job mentoring to ensure their skills in this area were sufficient, however, a staff member that commenced in February 2023 did not receive this training.

Judgment: Not compliant

Regulation 8: Protection

Overall, appropriate measures were in place to keep residents safe at all times. The concerns in relation to the systems around financial safeguards have been addressed under Regulation 12. Staff received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff spoken with, were found to be knowledgeable in relation to their responsibilities in ensuring residents were kept safe at all times. Residents had intimate care plans in place which detailed the level of support required.

Judgment: Compliant

Regulation 9: Residents' rights

Although some positive practices were noted in relation to residents' rights within the centre, improvements were needed to ensure best practice in this area was adhered to on a continuous basis. For example, a resident's bedroom door was left open when they were in their bed. There was no evidence in place to indicate if the resident had been consulted in this practice or if alternative methods had been explored in relation to this. The residents right to privacy and dignity was not been upheld.

Judgment: Substantially 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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Roseville OSV-0005738

Inspection ID: MON-0033681

Date of inspection: 20/11/2023 & 21/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • As part of the ongoing review of WTE by the Provider the DOS and ADOS are completing another full review of staffing standard for each designated centre – including Roseville. This will be completed by 12.01.2024 and PIC and TL advised of any changes in relation to same. • PIC and TL ensure cover of vacancies by relief and agency staff and also use of overtime within working time act regulations. • To further support each person's weekly opportunities as part of the Personal Plan framework, PIC & TL are leading out on Focus on Future meetings to plan and ensure staffing levels are available to support each person within their roles.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • PIC and Team Leader are meeting on a weekly basis for governance meetings to discuss people supported, review audit actions and compliance plans and develop the PIC monthly status report for DOS and ADOS – this will ensure oversight and communication of support needs in relation to all matters for people supported and the staff team. • PIC will support TL to lead out on person supported monthly reviews & Focus on Future Meetings, ensuring oversight of person supported personal plan. • Audit and update of person supported files to be completed by 31.01.2024 • Lead auditor will complete annual review by 31.01.2024 • A data cleanse will be completed on all files by 19.01.2024, relevant information kept	

and reviewed, and archiving completed as required.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• Asset Lists were reviewed and updated including all personal possessions of value over €50 for people supported – to be completed by 31/12/2023.
• Reimbursement for item charged in error completed by finance department by 20.12.2023.
• TL and/or PIC to complete finance audits every month for oversight & check of quality spend.
• Finance will roll out of person supported Soldo cards in January 2024. This will facilitate up to date statements for each person's spendings on a daily basis.
• The backlog of statements for people supported in the old systems are currently underway and will be completed by a relevant team member in January 2024. All statements up to 30 September 2023 will be issued to people supported by 31 January 2024 All people supported will have statements up to 31 December 2023 by latest 31 March 2024.
• Circle of Support Meetings to be held for spends of high value items/occasions, keeping in line with Aurora approach to Assisted Decision-Making Capacity Bill.
• Lead auditor will review monthly finance audit and amend to include cross referencing (By 11.01.2024)

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
PIC and Team Leader are taking the following actions in relation to fire evacuation:
• Discuss fire evacuation plan and response from other designated centre with PIC of responding house relevant SOP, risk assessments and support plans for each person supported.
• Complete two night-time fire drills by 25.01.2024 with support from the responding house in order to plan for a timely response and safe evacuation.
• Ensure clear detail in relation to fire evacuation procedures and manual handling procedures are evident in SOP and risk assessment.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• In line with personal plan policy PIC & TL will complete a full review of each person's health using relevant documentation to include the new Health Biographies will be implemented by 31/01/2024.
• On the Job Mentoring is scheduled by the PIC and Team Leader for the staff team in relation to documenting of health by 31/01/2024. This includes medical data sheet; medical appointment forms; daily notes on the DMS system; the protocol for any follow up that may be required and documentation of same.
• Further review will then be completed in preparation for each person's annual review & visioning meeting.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
PIC and Team Leader are taking the following actions in relation to maintaining person supported right to privacy and dignity:
• Presently person supported bedroom door is left open to monitor seizure activity as Oxygen therapy is required immediately on start of seizure activity.
• PIC & TL will complete some research into seizure monitoring equipment suitable for person supported. Same will be completed by 31/01/2024.
• Circle of Support to be held with person supported to support person to make their will and preference known around the bedroom door being left open while in bed. To be completed by 19.01.2024.
• PIC & TL will discuss upholding person supported rights to privacy and dignity to include when person supported is in bed at January team meeting

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/01/2024
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.	Substantially Compliant	Yellow	12/01/2024
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	31/01/2024

	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.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	25/01/2024
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	25/01/2024
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	31/01/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is	Substantially Compliant	Yellow	31/01/2024

	respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			