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:	Bród
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	23 May 2023
Centre ID:	OSV-0005809
Fieldwork ID:	MON-0035095

About the designated centre

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

Bród designated centre provides community based living arrangements for up to four adult residents. Bród is a detached one storey, 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 large 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 person in charge assigned to the centre who also has responsibility for another designated centre a short distance away. Three staff work during the day to support residents in having a full and active life and two waking night staff are also in place. 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
Tuesday 23 May 2023	09:30hrs to 15:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This was an unannounced inspection, completed for the purpose of monitoring ongoing compliance against the Regulations and standards. Overall findings of this inspection were, that this was, for the most part a well managed and well run centre. Residents were supported by a staff team who were familiar with their care and support needs. The house was warm, clean and homely and suited to the needs of the residents who lived here. The residents were supported to lead busy and active lives of their choosing.

This centre is registered for a maximum of four residents and there were three individuals living in the centre on the day of inspection with a fourth resident identified to move into the house within the following few weeks. The inspector had the opportunity to meet and spend time with all three residents living in the centre over the course of the inspection.

On arrival the inspector was directed to an area in the hallway where hand sanitiser was available and which contained a visitors book and sign in information. The centre was located on a quiet cul-de-sac on the outskirts of Kilkenny City and within easy access of the city centre. There were a number of vehicles in the centre to support the residents to attend activities and events in their local community.

There was a large well maintained patio area and garden to the rear of the property and the inspector observed that the patio was frequently accessed and used, with two resident bedrooms opening directly onto it. To the front of the premises was a small but well planted and maintained garden with shrubs and flowers. The large bungalow was spacious, airy, and colourful throughout. There were a number of communal areas available for residents to spend their time. These included a large dining/living room, a kitchen, and a second living room.

Two residents were in an open plan dining/sitting room and the third resident was being supported with personal care by staff as the inspector arrived in the centre. The inspector observed that one resident was listening to music on the television and another resident had just finished their breakfast. Following their breakfast the resident was supported to explore musical instruments such as a tambourine and other noise making objects.

All residents in the centre presented with complex communication needs and were non-verbal although they were skilled in using non-verbal cues to express core messages. Where a resident presented with a visual impairment, the staff were observed as skilled in helping them to anticipate what was happening and about to happen and to explore their environment. Later in the day a staff member supported two residents to participate in baking buns and in experiencing the sensory aspects of this experience such as smell and touch. Staff were observed joining residents at the table for a cup of tea and chatting to them as they carried out everyday

activities.

One resident who loves music was supported to attend music therapy in the morning and this is an activity that they enjoy and frequently attend. Another resident was going for a walk in a local park and the inspector observed the staff supporting them to apply sun cream before going out. Over the course of the day residents went out both for planned activities and with support staff in everyday activities such as shopping. Individuals were given time on their own if they indicated they would like that or spent time with each other or with staff. The inspector found that the residents had strong friendships with their peers who lived in other homes operated by the provider and there was evidence of visits and time spent with friends. he inspector observed residents being treated with dignity and respect during the inspection. Staff were observed to knock before entering rooms and to offer residents choices in relation to how and where they spent their time. There was information available on the availability of advocacy services and information regarding their rights was discussed as part of resident meetings.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

Overall, the findings of this inspection was that residents were in receipt of a good quality and safe service. Minor improvements were required to the frequency that the provider was monitoring the quality of care and support residents received. The provider and person in charge were working to support residents to make choices in their day-to-day lives.

The person in charge was working full-time in the centre and they were supported by either an identified director or assistant director of services who they also reported to. The director or assistant director of operations was also present in the centre regularly and available to the person in charge and staff by phone as required. The provider's systems to monitor care and support had been identified by the provider as requiring review as they had not consistently met the requirements of the Regulations to date. The inspector found that the provider was taking steps to improve the auditing content and time frames. The provider six-monthly unannounced audits had not taken place as required however, the most recent from October 2022 had identified a number of actions that had since been completed. An annual review for 2022 was complete and a quality improvement plan had been developed as an outcome of this.

There were systems in place to ensure the workforce were aware of their roles and responsibilities, and carrying out their duties to the best of their abilities. Staff

meetings were occurring regularly and there were handovers at the beginning of each shift. Staff had completed mandatory training in line with the centre's statement of purpose, and they had completed additional training in line with residents' assessed needs.

Regulation 15: Staffing

The provider had ensured there was a staff team in place that was providing continuity of care and support to residents. There were regular reviews of residents' assessment of need which the provider used to inform staffing levels. There were three staff currently on leave in the centre at the time of the inspection. Cover for which the provider was providing from either their relief panel or via the use of two consistent agency staff. This provided an assurance that there were consistent staff members in place to fill these positions until staff returned from leave. A number of residents also had access to personal assistant hours to enhance their individual time in the community. These hours were provided by familiar named staff who appeared on the centre roster.

Planned and actual rosters were in place, and from a sample of rosters reviewed, all the required shifts were covered. However the rosters were not always reflective of the actual position regarding staffing supports at night. This centre had two waking staff on the rota at night. Other centres operated by the provider could call to access a second staff if needed by them for provision of personal care. This meant that this centre was regularly left with a single staff member for varying times at night however, there were no formal systems in place to record when this occurred. As this information was not monitored over time it was not possible for the person in charge to give the inspector an idea of how often the centre was left with below minimum staffing levels at night.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff team were supported to access training and refresher training as required in this centre. The person in charge monitored the training requirements and additional training that supported the provision of individualised care to the residents was promoted. All staff were supported to complete human rights training and this was scheduled for completion within the next month.

Where some staff were overdue refresher training in areas such as hand hygiene, safe medication management and safeguarding the provider was aware of these

and they had been scheduled for staff to attend.

Staff were supported to complete their role by the provision of formal support and supervision. The inspector found that the person in charge had a schedule of formal supervision for the year in place and had met with all staff on one occasion to date. However, supervision had not been provided in line with the provider's policy over the course of 2022.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were clearly defined management structures and staff had specific roles and responsibilities in the centre. The centre was managed by a person in charge who was also on the roster to provide care and support to residents each week. This ensured they were familiar with residents' care and support needs and their responsibilities in relation to the regulations. They were supported in this role by either the assistant director or director of services. There was a clear focus on quality improvement in the centre.

The provider and person in charge had systems in place to ensure oversight and monitoring of care and support for residents and as stated these were currently under review and development. These included, an annual review and six monthly reviews although the frequency of these required improvement. These audits and reviews when completed were identifying areas for improvement and these actions were being logged, tracked and completed. This resulted in improvements in relation to residents' care and support and in relation ot their homes.

Regular staff meetings were occurring with minutes reviewed by the inspector, these were seen to be resident focused. The person in charge also attended other provider communication meetings and there were senior management meetings and health and safety meetings that also provided a forum for sharing information that may be pertinent to the operation of the centre.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider was in the process of supporting a new resident to move into the centre. There was a clear admission process in place and the inspector found that the provider and person in charge were adhering to all time lines and guidance as laid out by their policy and associated procedures.The new resident had

visited the centre on a number of occasions and the staff team had been supported to visit the resident in their current home. They had been provided with easy-to-read documentation and had met with the provider alongside their family to participate in decisions such as decoration decisions for their room. In addition the resident and their family had created a photograph based book which was available in the centre to share with other residents and their families as part of an agreed 'getting to know you' process.

The registered provider and person in charge had completed a suite of assessments in line with their policy including compatibility assessments for the new resident and the residents already living in the house. Health and Social Care professionals had also completed assessments to ensure that the premises and equipment in the house was suitable. A contract outlining the services to be provided and any fees that may be occurred had been drawn up and discussed with the resident and their family and was ready for signing on admission.

Judgment: Compliant

Quality and safety

From what the inspector observed and was told, and from reviewing documentation, it was evident that residents were in receipt of a good quality and safe service. Residents were being supported by a staff team who they were familiar with and they were engaging in activities of their choice in their home or in their local community.

Residents were actively supported and encouraged to connect with their family and friends and to take part in activities in their local community. They were being supported to be independent and to be aware of their rights. They were also supported to access information on how to keep themselves safe and well. Residents who wished to, were being supported to access aspects of day services, and to take part in activities in accordance with their interests.

The provider had identified that some improvements were required in relation to the financial support and oversight systems in place and these were found by the inspector to require further review. Residents were happy for the inspector to move through the house and to observe their private rooms. These had been decorated to reflect individual preferences and needs. Communal areas were warm and comfortable and had been decorated with the residents' needs in mind.

Residents were protected by the polices, procedures and practices in place in relation to safeguarding and protection in the centre. Staff had completed training and were found to be knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse.

Regulation 12: Personal possessions

The provider and person in charge had ensured that all residents had access to personal items and their photographs and personal mementos were displayed throughout their home which presented as individual to those who lived there. However, improvement was required in financial oversight systems and in the practices to safeguard resident's finances and access to their monies.

The provider had identified that residents did not have access to bank accounts. Residents in this centre had Health Service Executive (HSE) Private Patient Property Accounts (PPPA) with clear pathways in place to guide in the use of these. Access to finances however, have to be requested in advance through the main central office. These restrictions had previously been identified and the provider has acknowledged that this practice requires review and there is a plan in place.

In addition to the difficulty in freely accessing their monies the inspector found that the residents in this centre were not safeguarded by the financial oversight practices in place. The inspector found a number of errors in the daily checks and in the oversight of actual monies present in wallets. The person in charge and the inspector on review found discrepancies between actual amounts present and the amount recorded that should be present. There were discrepancies between day and night records and incorrect amount entered on a number of days in the month prior to the inspection. This all required review and checking to ensure that residents' money was accounted for.

Judgment: Not compliant

Regulation 17: Premises

The centre comprises a large bungalow at the end of a quiet cul-de-sac on the outskirts of a small city. The premises is set in it's own standalone site and is registered to provide a home for four individuals. Overall, the centre was designed and laid out to meet the needs of residents living in the centre. The house was spacious, warm, clean and comfortable. Shared spaces were homely and residents' bedrooms were decorated in line with their wishes and preferences. Externally there was space for residents to relax and to enjoy their garden and the patio was accessible with colourful furniture which had been designed with the residents' needs in mind.

There were systems in place to log areas where maintenance and repairs were required and evidence that a number of works had been completed since the last

inspection including painting, decoration and improvement to storage.

Judgment: Compliant

Regulation 27: Protection against infection

The health and safety of residents, visitors and staff was being promoted and protected through the infection prevention and control policies, procedures and practices in the centre. Residents and staff had access to information on infection prevention and control, and there were contingency plans in place in relation to COVID-19. Staff had completed a number of additional infection prevention and control related trainings.

There were cleaning schedules in place developed to ensure that each area of the houses a were regularly cleaned. However, the inspector found that there were some gaps in the recording of cleaning within the schedules, in addition to not all areas identified such as the bath and bath aid. There were suitable systems in place for laundry and waste management and for ensuring there were sufficient supplies of PPE available in the centre.

Where there were specific healthcare infection risks these had been identified and the person in charge had clear risk assessments in place and associated restrictive practices which were under continuous review.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were fire containment measures in place in the centre including fire doors and self-closing mechanisms. There were systems to ensure fire equipment was serviced and maintained. The inspector found that frequent audits and reviews of fire safety processes and equipment were being completed.

Residents had risk assessments and detailed personal emergency evacuation plans in place which were reviewed and updated following learning from fire drills. Fire drills were occurring regularly. However, a drill to demonstrate that each resident could evacuate the centre when the least number of staff are on duty had not been completed. A drill in line with the providers policy had been completed with two staff however, as stated there were regular periods where one staff member could be present. No simulation or real time checks were available for review regarding this scenario nor to indicate how long it would take staff to attend to support from another centre operated by the provider. This was important as some residents'

required two staff to support in transferring from one environment to another. A drill completed using resident beds had demonstrated actions were required and these had not been completed or followed up and this drill had been completed in October 2022.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' assessments and personal plans and found that they were person-centred and detailed in nature. Residents' abilities, needs, wishes and preferences were highlighted in their plans. There was evidence of a clear link between assessments and plans, and evidence of ongoing review and evaluation of them. Assessments were occurring at least annually and were multidisciplinary including the resident and their representative.

Residents' opportunities to develop and maintain relationships and to hold valued social roles formed part of the development of residents' goals and these were regularly discussed at meetings between residents and their keyworkers. Photographs were taken over the course of the year and had been placed into individual albums, this supported residents in communicating about their goals and interests. Daily and weekly schedules and options to support choice making were available for all residents.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to maintain and experience best possible health. An annual overview of assessed health needs and supports was in place and this was also used to maintain an overview of appointments and other health related matters. Health assessments informed residents' plans of care and these were found to be regularly reviewed and updated to ensure they were reflective of their needs.

All residents had access to the GP of their choice and to attend health and social care professionals as required. Where residents had hospital admissions they were supported during their visit or stay with up-to-date hospital care plans and staff support as indicated. Information was provided to residents in an accessible format and they were supported to be involved in making healthcare related decisions that impacted on them and their quality of life.

Judgment: Compliant

Regulation 8: Protection

Notwithstanding the areas discussed under Regulation 12, the residents in this centre were protected by the policies, procedures and practices relating to safeguarding and protection.

Safeguarding plans were developed and reviewed as required. Residents had assessments completed which guided the development of personal or intimate care plans. Areas where residents may be vulnerable had been considered and the associated risks assessed to guide the development of personal support plans. Staff had completed training in relation to safeguarding and protection, and those who spoke with the inspector were knowledgeable in relation to their roles and responsibilities.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that the rights and diversity of residents was being respected and promoted in the centre. Residents' personal plans, keyworker meetings and their goals were reflective of their likes, dislikes, wishes and preferences. Residents were consulted to gather their thoughts on what it was like to live in the centre.

Residents were very comfortable with staff and in how staff respected their wishes and listened to what they had to say. The staff talked about choices and how they adapted them so that residents could fully make decisions. Residents were supported to make every day decisions in relation to areas such as where and how they spent their time, what they ate and drank, and how involved they were in the day-to-day running of the centre.

Some residents had accessed independent advocates, and there was information available and on display in relation to independent advocacy services and the confidential recipient. Residents were also supported to be members of local advocacy groups and one resident had attended a meeting with local councillors to advocate on matters that were important to them.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bród OSV-0005809

Inspection ID: MON-0035095

Date of inspection: 23/05/2023

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: PIC is continuously reviewing Bród's roster to ensure familiar agency staff to work in the centre when required. Aurora's night managers are supernumerary and available to the centre in the event of an emergency. The PIC implemented a log on the 04.06.2023 to document when Bród team members are required to support in another designated centre. This log will be reviewed monthly by PIC & DOS to review the data, and consider if actions are required. As part of Aurora's recruitment & retention strategy, a working group has commenced meeting on a monthly basis. The working group consists of management team members from a number of functions (HR, Finance Governance & IT, Operations) and three members of the SMT including the CEO. The working group is actively addressing the vacancies with proactive measures taken. More recently, they have organised a Recruitment Open Day with another scheduled for mid-July 2023. Aurora also has a presence across social media with the immediate aim of raising the providers profile in Kilkenny and environs to attract suitable employees. Exploration of profiled recruitment through agencies is also ongoing.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The importance of completion/refreshing of training was discussed at the Bród monthly team meeting on 24.05.2023 and will be on agenda for all team meetings.	

Staff have been scheduled for their outstanding training and all will be completed by 28th July'23

Present PIC has QC schedule developed for 2023 and has been actively working from it. PIC will discuss training with each staff member during the quality conversations, scheduled held in quarter two.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PIC will continue to attend all Quality Assurance, governance and management meetings held. As part of the current Aurora Interim Governance & Management Plan, the PIC is being supported directly by the Director of Services and Assistant Director of Services, through Quality Conversations and as required through visits, meetings etc.

Providers Annual completed in March 2023, this was viewed by HIQA inspector and PIC is working from actions identified.
Aurora's lead Auditor has developed a schedule for annual reviews and six-monthly reviews with all functions involved in auditing. Lead auditor has set dates for audits and will monitor to ensure they are completed within set time frame.
On receipt of audit the PIC will discuss the learning from audits at next Team Meeting, and agree on identified staff to address actions.

The PIC has been adhering to the scheduled monthly team meetings and will continue to ensure audits are on agenda for discussion to take learning from them and actions assigned to staff.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Following HIQA inspection PIC had conversation with staff on a daily basis high lightening to staff team the seriousness of each discrepancy. PIC also discussed at team meeting on 24.5.2023
PIC reviewed the practice in house and confirmed that the day staff as identified on

planner check finances at start and end of shift and night staff check at start of duty

PIC ensures ongoing Governance over person supported financial accounts. Persons supported accounts are currently under review with Aurora Quality and Financial department.

Finance Department has reviewed the Aurora Finance Policy and audit system to amend with further clarification on
- Completion of finance checks (including financial statements)
- Quality of audits completed, review of guiding questions.
-
Expenditure ledgers of debit cards used by the gentlemen needed improvements, interim plan development and devised. As per our Finance department, a new debit card, Soldo has been rolled out as Quality Initiative across Aurora for house budgets in June 2023. As a next development Soldo cards will be implemented for people we support. Actions for this are to be completed in advance of a meeting on the 24th May so the finance department will have full suite of guidance out after that.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
PIC has reviewed cleaning schedule 02.06.2034 to ensure all areas were on schedule, and identified duties to be complete by night staff.
PIC highlighted with all staff gaps in recording, these tasks are identified as delegated duties, PIC will be checking the delegated duties.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Night drill was completed on 12.06.2023 to follow up on the identified action from October 2022. The PIC has planned for further fire drills to ensure practice of fire evacuation with different scenarios and minimum staffing levels in the designated centre.

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	04/06/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	07/07/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	06/06/2023
Regulation 23(1)(c)	The registered provider shall	Substantially Compliant	Yellow	06/06/2023

	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 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	23/06/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the	Substantially Compliant	Yellow	02/06/2023

	standards for the prevention and control of healthcare associated infections published by the Authority.			
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.	Substantially Compliant	Yellow	12/06/2023