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:	Walk A
Name of provider:	Walkinstown Association For People With An Intellectual Disability CLG
Address of centre:	Dublin 12
Type of inspection:	Unannounced
Date of inspection:	06 December 2023 and 07 December 2023
Centre ID:	OSV-0003403
Fieldwork ID:	MON-0038670

About the designated centre

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

Walk A is a community residential service comprising three houses located in South Dublin suburban residential areas. Walk A aspires to support residents with an intellectual disability to achieve a self-determined, socially inclusive life. Walk A provides residential facilities and staff support to residents to empower them to make informed choices in relation to their lives. Each resident is accommodated in a single-occupancy bedroom with kitchen, living room, bathroom and garden areas which are suitable and accessible. The service is registered to accommodate up to 12 adult residents and is resources with social care workers led by a team leader in each house and person in charge of the service overall. The service has access to vehicles and residents have access to local amenities such as shops and cafés.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 December 2023	09:15hrs to 16:30hrs	Kieran McCullagh	Lead
Thursday 7 December 2023	08:55hrs to 12:25hrs	Kieran McCullagh	Lead

What residents told us and what inspectors observed

This was an unannounced inspection completed over two days and was facilitated by the person in charge and team leaders. Over the course of the inspection, the inspector visited the three homes that made up the centre, met with staff members on duty and with five of the residents who lived there.

The centre was registered to accommodate 12 residents and is comprised of three homes, each located in a South Dublin suburb. There were three residents living in one house, four residents lived in another and two residents lived in the third home. There were three vacancies at the time of inspection.

The inspector carried out a walk around of each home in the presence of the team leader. The inspector observed that each house was well maintained and the residents had artwork and photographs on display throughout. Each of the residents had their own bedroom which had been personalised to the individual resident's tastes and was a suitable size and layout for the resident's individual needs. This promoted the residents' independence and dignity, and recognised their individuality and personal preferences.

The inspector met one resident who lived in the first house visited by the inspector. This resident told the inspector that they were very happy in their home and they spoke about their plans for the day as chosen by themselves. They showed the inspector their room and DJ equipment which they enjoyed using and spoke about a goal they had recently achieved of hosting their own show in a local radio station.

In the second house, the inspector met with all residents that lived there. Residents spoke briefly to the inspector. These residents indicated to the inspector that they were very happy living in the centre. From speaking with residents, it was evident that they felt very much at home and were able to live their lives and pursue their interests as they chose.

Staff were observed to interact with residents in a respectful and supportive manner. For example, knocking and seeking permission to enter the residents' bedrooms. Residents were supported to engage in meaningful activities on an individual basis. The inspector had an opportunity to look at some of the resident's personal plans, which included photos of activities residents had engaged in during the year to date. Examples of activities that residents engaged in included, employment, holidays, trips to music festivals, shopping and dining out.

Staff members on duty were observed and overheard to be pleasant and respectful with residents during the inspection. Residents were observed to seek staff out should they require support and staff were observed to respond appropriately and to be familiar with residents' needs. On speaking with staff throughout the inspection, the inspector found that they were knowledgeable of residents' needs and the supports in place to meet those needs. Staff were aware of each resident's likes and

preferences.

The person in charge and team leaders described the quality and safety of the service provided in the centre as being very good and personalised to the residents' individual needs and wishes. Observations carried out by the inspector, feedback from residents and documentation reviewed provided suitable evidence to support this.

In addition, the person in charge spoke about the changing needs of one resident and supports in place to manage same. They advised that this resident had been hospitalised at the start of October due to a decline in their mental health. As a result of this, additional staffing resources were required in one house to ensure the care and support needs of this resident could be met. Although the provider was actively liaising with their funder and had submitted a proposal to source required staffing, this had not been implemented on the day of the inspection. This is discussed further in the report.

In summary, residents indicated they were happy living in the centre. Staff described meaningful opportunities for residents to engage in activities they enjoyed and the inspector observed residents taking part in activities they enjoyed at home and to leave the centre to engage in activities in the community. Residents were supported to stay in touch with the important people in their lives and to make choices and decisions about their day-to-day lives. The service was operated through a human rights-based approach to care and support, and residents were being supported to live their lives in a manner that was in line with their needs, wishes and personal preferences.

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

Capacity and capability

The purpose of this inspection was to monitor levels of compliance with the regulations. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

The findings of the inspection indicated that the provider had the capacity to operate the service in compliance with the regulations and in a manner which ensured the delivery of care was person-centred. However, improvements were required with regard to staffing, fire precautions and positive behavioural support and these are discussed in the body of the report below.

The inspector found that the provider and person in charge were striving to ensure that the governance and management arrangements in place provided a safe and

good quality service to residents. The management structure in the centre was clearly defined with associated responsibilities and lines of authority.

The person in charge was full-time and they held responsibility for the day-to-day operation and oversight of care. They were supported by a team leader in each premises, all of whom were knowledgeable about the support needs of residents. However, a review of a sample of rosters indicated that there was a reliance on the use of relief staff to meet the assessed staffing complement in the designated centre. In addition, the provider had failed to increase staffing in line with the identified changing needs of one resident.

From a sample of training records viewed, the inspector found that staff were provided with training to ensure they had the necessary skills to respond to the needs of the residents. For example, staff had undertaken a number of in-service training sessions which included safeguarding of vulnerable adults, fire safety and training in relation to a resident's specific assessed needs. Supervision records reviewed were in line with organisation policy and the inspector found that staff were receiving regular supervision as appropriate to their role.

The provider had systems in place to monitor and audit the service. An annual review of the quality and safety of care had been completed for 2022 and, a six-monthly unannounced visit to the centre had been carried out in October 2023. On completion of these audits, action plans were developed to address any issues identified in a timely manner.

An up-to-date statement of purpose was in place which met the requirements of the regulations and accurately described the services provided in the designated centre.

The person in charge was aware of all complaints which were followed up and resolved in a timely manner.

Regulation 15: Staffing

The staff team comprised of the person in charge, team leaders and social care workers. All staff members engaged by the inspector during the course of the inspection were knowledgeable about the care needs of residents, and could confidently describe their role in relation to various aspects of the support needs of residents.

However, due to vacancies and leave within the existing staff team the provider was attempting to ensure continuity of care and support through the use of regular relief staff. The inspector reviewed planned and actual rosters maintained and found there was a reliance on the use of relief staff to meet the assessed staffing complement. For example, in the months of October and November the centre roster had documented a total of 110 shifts covered by relief staff with a further 65 shifts planned for the month of December.

In addition, due to the changing needs of one resident additional staffing was required in one house to ensure the care and support needs of this resident could be met. Although this issue had been identified by the provider and at the time of inspection a proposal had been submitted to the provider's funder to address these concerns, the provider had failed to increase staffing in line with the identified changing needs of the resident.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had ensured that all staff had access to appropriate mandatory training to ensure staff met the assessed needs of the residents. There were mechanisms in place to monitor staff training needs and to ensure that adequate training levels were maintained. Staff received training in a number of areas, such as fire safety, safeguarding and managing behaviour that is challenging.

In addition, staff had received training in relation to a resident's specific assessed needs and further training had been scheduled for all staff in January 2024.

The inspector found that staff were receiving regular supervision as appropriate to their role. Supervision records reviewed were in line with organisation policy and included a review of the staffs personal development and the provision to raise concerns.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured information and documentation on matters set out in Schedule 2 were maintained and were made available for the inspector to view. The inspector reviewed a sample of staff records and found that they contained all the required information in line with Schedule 2.

Judgment: Compliant

Regulation 22: Insurance

The provider effected a contract of insurance against injury to residents and other risks in the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

Over the course of the inspection, there was a clear management structure in place with clear lines of accountability. It was evidenced that there was regular oversight and monitoring of the care and support provided in the designated centre and there was regular management presence within the centre.

The person in charge was suitably qualified and experienced. They had a comprehensive understanding of the service needs and had structures in place to support them in meeting their regulatory responsibilities. Staff spoken with were clear on their roles and responsibilities and of how to escalate concerns or risks through the chain of command to the provider level.

Six-monthly unannounced visits had taken place in line with regulatory requirements and where actions were identified, they were tracked to ensure they were progressed in a timely manner. The provider had carried out an annual review of the quality and safety of resident care in the centre for 2022. These reviews also included detail on the consultation which had taken place with residents and their representatives.

Judgment: Compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place which met the requirements of Schedule 1, and clearly set out the services provided in the centre and the governance and staffing arrangements.

A copy of the statement of purpose was readily available to the inspector on the day of inspection. It was also available to residents and their representatives in an easy-to-read version.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had an up-to-date complaints policy and associated procedures were in place to guide staff. There was an easy-to-read version available for residents and the details of who to speak to if they wished to make a complaint was found to be

on display in the hallway of each home within the designated centre.

Residents were supported to make complaints where they chose to, and a record of these was maintained. The inspector reviewed the complaints and found that complaints were being responded to and managed locally. The person in charge was aware of all complaints and they were followed up and resolved in a timely manner.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. Overall, the inspector found that residents felt safe in their home and were in receipt of a good quality service. However, there were enhancements required to the fire precautions and reporting and monitoring of restrictive practices, which is discussed later in the report.

Overall, the inspector found that the residents in this centre were supported to enjoy person-centred support which was respectful of their choices and wishes. The person in charge and staff were striving to ensure that residents lived in a supportive environment where they were empowered to live as independently as possible.

The inspector found the atmosphere in the centre to be warm and relaxed, and residents appeared to be happy living in the centre and with the support they received.

The inspector reviewed a sample of residents' files. It was found that residents had an up-to-date and comprehensive assessment of need on file. Care plans were derived from these assessments of need. Care plans were comprehensive and were written in person-centred language. Residents' needs were assessed on an ongoing basis and there were measures in place to ensure that their needs were identified and adequately met. Support plans included personal and intimate care, positive behaviour support and healthcare plans.

Effective arrangements were also found with regards to the assessment of residents' needs. This process was maintained under regular review by the person in charge and where any changes to residents' needs or care interventions were identified, this was communicated to staff in a timely manner.

The organisation's risk management policy met the requirements as set out in Regulation 26. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre. Control measures were in place to guide staff on how to reduce these risks and to maintain safety for residents, staff and visitors. Individualised specific risk assessments were also in place for each resident. It was seen by the inspector that these risk assessments were regularly

reviewed and gave clear guidance to staff on how best to manage identified risks.

The centre was equipped with fire safety systems including a fire alarm, emergency lighting, fire extinguishers and fire doors. Fire safety systems were being serviced at regular intervals by an external contractor to ensure they were in proper working order. Fire drills were being carried out regularly. Each resident had a personal emergency evacuation plan (PEEP) in place which identified a personal evacuation plan for day and night.

However, it was observed, during the walk-around of the centre, that a number doors were not fire complaint and some fire compliant doors in place did not have self-closing mechanisms. The provider had commissioned a review of fire safety measures in the centre and identified deficits and a proposal had been submitted to the provider's funder to address this.

Positive behaviour support plans were developed for residents where required. The plans were up to date and readily available for staff to follow. Staff had also completed training in positive behaviour support to support them in responding to behaviours of concern.

Most restrictive practices in the centre were logged and reported, however through discussion with the person in charge and staff team, it was identified that there were additional restrictive practices in the centre, which had not been logged as such by the provider or notified to the Chief Inspector. For example, staff offices were locked and the keeping residents' finances in a secure place in the centre. The person in charge agreed that, in line with current best practice, these should be logged as restrictive practices.

There were good arrangements, underpinned by robust policies and procedures, for the safeguarding of residents from abuse. Staff working in the centre completed training to support them in preventing, detecting, and responding to safeguarding concerns. Staff spoken with were familiar with the procedure for reporting any concerns, and safeguarding plans had been prepared with measures to safeguard residents.

Regulation 12: Personal possessions

The provider and person in charge ensured that residents had access to their personal items. The residents' belongings, photographs and personal equipment were available to them in their home both in their bedrooms and in communal areas.

The provider had clear financial oversight systems in place with detailed guidance for staff on the practices to safeguard resident's finances and access to their monies. The inspector found that residents had assessments completed that determined the levels of support they may require.

The inspector reviewed a sample of financial records where residents received support from staff to manage their finances. Each resident had their own bank account and staff maintained records of each transaction, including the nature and purpose of transactions and supporting receipts and invoices.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had ensured residents were provided with a guide outlining the services and facilities provided in the designated centre in an appropriate format.

In addition, there was an easy-to-read contract of care and tenancy agreement in place, which was reviewed annually.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had suitable systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies.

There was a risk management policy in place which included all the requirements of the regulations. Arrangements were also in place for identifying, recording, investigating and learning from incidents, and there were systems for responding to emergencies.

Risk assessments and management plans were in place for all identified risks in the designated centre. There was particular emphasis on managing risks that were individual to each resident. These risk assessments were found to be robust in nature and they were reviewed on a regular basis.

There was clear evidence of newly identified risks being identified in a timely manner, and control measures being put in place to mitigate such risks.

Judgment: Compliant

Regulation 28: Fire precautions

Each house had suitable fire safety equipment in place, including emergency

lighting, a fire alarm and fire extinguishers which were serviced as required.

The fire panel was addressable and easily accessed in the entrance hallway of each house. However, it was also observed on the walk-around that a number doors were not fire complaint and some fire compliant doors in place did not have self-closing mechanisms. The provider had commissioned a review of fire safety measures in the centre and identified deficits and a proposal had been submitted to the provider's funder to address this.

The person in charge had prepared evacuation plans to be followed in the event of the fire alarm activating, and each resident had their own evacuation plan which outlined the supports they may require in evacuating.

Regular fire drills were completed, and the provider had demonstrated that they could safely evacuate residents under day and night time circumstances. Staff were aware of evacuation routes and the individual supports required by residents to assist with their timely evacuation.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment of need and personal plan in place. From the sample reviewed, residents' assessments clearly identified their care and support needs. Assessments and plans were regularly reviewed and updated with any changes in need. These assessments were used to inform plans of care, and there were arrangements in place to carry out reviews of effectiveness. Multidisciplinary professionals were involved as appropriate in creating support plans.

Each resident had an accessible person-centred-plan with their goals and aspirations for 2023. These included residents' goals and the actions required to achieve them. Residents were supported to set goals that were meaningful for them. For example, one resident had set and achieved two goals; going on holiday and attending a music festival.

Judgment: Compliant

Regulation 6: Health care

The provider and person in charge ensured that residents were being supported to enjoy best possible health. There was evidence of regular healthcare appointments with; general practitioner, dietition, chiropodist and ophthalmologist. Staff engaged by the inspector described the interventions and support required by each resident

to ensure the best possible health outcomes.

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' care plans and these were found to be regularly reviewed and updated to ensure they were reflective of their needs. Risk assessments were in place to address any risks identified in health care plans.

Multi-disciplinary input was routinely sought as part of the re-assessment of residents' needs and where recommendations were made, these were incorporated within the health care plans for residents.

All residents accessed a GP of their choice and health and social care professionals in line with their needs and the resulting care plans were detailed in nature and guiding staff practice. Where residents had hospital admissions they were supported with up-to-date hospital care plans and staff support as indicated.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. Clear behaviour support plans were in place to guide staff on how best to support these residents, and regular multi-disciplinary input was sought in the review of residents' behavioural support interventions.

The inspector reviewed a sample of behaviour support plans in place for residents. The plans detailed proactive and reactive strategies to support residents in managing their behaviour. They were devised in consultation with the clinical team and reviewed regularly as per the providers policy.

There was a restrictive practice committee in place within the organisation which authorised and regularly reviewed any restrictive practices in the centre. There were a number of restrictive practices in one premises. However, not all restrictive practices, utilised in the centre, had been reported to the Chief Inspector on a quarterly basis, as required. For example, staff offices were locked, which had not been recognised or assessed as a restrictive practice.

In addition, through discussion with the person in charge and staff it was identified that securing residents' finances in a secure place in the centre, although requested by some of the residents, would likely meet the definition of a restrictive practice as set out in the provider's associated policy.

A review of the restrictive practices was required to ensure that all restrictive practices were logged, regularly reviewed and to ensure they were the least restrictive, for the shortest duration, and risk assessed in line with the provider's

policy.

Judgment: Substantially compliant

Regulation 8: Protection

Overall good practices were in place in relation to safeguarding. Any incidents or allegations of a safeguarding nature were investigated in line with national policy and best practice.

The provider had appropriate arrangements in place to safeguard residents from harm or abuse. All staff had received training in safeguarding, and there was a safeguarding policy to guide staff.

All residents' personal plans were detailed in relation to any support they may require with their personal and intimate care. These documents were person-centred and identified residents specific preferences in this area including supports that made them feel safe and secure when staff were assisting.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Walk A OSV-0003403

Inspection ID: MON-0038670

Date of inspection: 06/12/2023 and 07/12/2023

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. By December 18th 2023, the PIC will have increased staffing in line with one person's changed needs in one location, for an identified time period. 2. By December 18th 2023, the PIC will have reengaged in recruitment process for vacancies within the designated center. 3. By January 22nd 2024, the PIC will have completed interviews for vacancies within the designated center. 4. By January 30th 2024, the PIC will confirm a return to original staffing levels for one person's changing needs in one location. 5. By January 30th 2024, the PIC will have reviewed the recruitment process with the Human Resources department to ensure safe staffing levels are in place.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. By January 5th 2024, the provider has received funding approval for fire safety works. 2. By January 30th 2024, PIC will have submitted maintenance request for fire safety works and to install automatic door holder for doors discussed in report. 3. On receipt of additional funding for fire safety measures and work from the funders, a planned schedule of works will begin in a phased implementation by 30th June 2024.	

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

1. By January 30th 2024, all restrictive practices utilized in the center will be reviewed by the PIC and restrictive practice committee.
2. By January 30th 2024, the PIC will have submitted quarterly notifications to the Chief Inspector for all restrictive practices utilized in the center.
3. By February 29th 2024, the PIC will have reviewed current practices for securing finances in place in the center and there will be a schedule outlined for recording and reviewing any restrictive practices in place.
4. By February 29th 2024, the PIC will have completed risk assessments for each location within the center where restrictive practices are in place.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/01/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/07/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures	Substantially Compliant	Yellow	29/02/2024

	are applied in accordance with national policy and evidence based practice.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	29/02/2024