Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Mixed).

Issued by the Chief Inspector

Name of designated centre:	Damara
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 November 2023 and 21 November 2023
Centre ID:	OSV-0003446
Fieldwork ID:	MON-0033034

About the designated centre

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

Damara is a designated centre that provides residential support for male adult males with intellectual disabilities. The centre is based on the outskirts of Kilkenny City on a campus style setting. The centre is one building divided into three separate bungalows, each with their own front door and it is located within walking distance of the city. The staff team consists of a person in charge, a social care worker and healthcare assistants. The residents supported in Damara present with intellectual needs and may have a diagnosis of autism and other needs. The home is a seven day residence open all year with no closures. There are three people supported in Damara at present. The centre, as confirmed in the statement of purpose is not open at present to new admissions. The centre has three service vehicles available for use by residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 20 November 2023	12:30hrs to 17:30hrs	Tanya Brady	Lead
Tuesday 21 November 2023	09:00hrs to 14:30hrs	Tanya Brady	Lead
Monday 20 November 2023	12:30hrs to 17:30hrs	Conor Brady	Support
Tuesday 21 November 2023	09:00hrs to 14:30hrs	Conor Brady	Support

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision on the registration renewal of the centre. Two other inspections were also carried out over the same 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. This report will outline the findings against this centre.

Overall findings were that the residents were in receipt of a safe service and that there were very good examples of a positive quality of life identified. The inspectors met each of the four residents over the course of the inspection and spoke to family representatives for two of the four residents also. The feedback and communication with the inspectors confirmed that residents were happy, active and supported to live a good life although family members also indicated that the turnover of staff and managers has been and remains a concern.

This centre had most recently been inspected in August 2022 as an unannounced inspection and at that time there were three individuals living in the centre. Since that inspection changes have been made to the internal layout of the building with the creation of a fourth apartment. The centre is currently at full capacity with four individuals living here. This inspection incorporated reviews of progress against provider identified actions arising from the previous inspection. The current inspection identified that levels of compliance had improved following actions taken by the provider and person in charge.

This centre comprises a single storey building located at the rear of a campus style setting. It has been subdivided into four self-contained apartments each with their own front door and although separated internally can be interconnected if required. Externally to the front of the building is a small communal garden space with a well used poly-tunnel, bicycle shed and paved area to sit. To the rear of the building the garden area is divided by fencing into four private gardens one per apartment. Residents' apartments were decorated in a manner personal to them and reflective of their personal needs and interests. One apartment was minimal and in keeping with a low sensory environment while another was set up to reflect a residents love of electronic equipment and computers in particular.

Over the two days of inspection each resident was observed to come and go from the centre at times set by them to engage in a wide variety of activities. These included a cinema trip, a hike, cycle rides and meals out. Residents were observed moving freely throughout their homes and to be familiar with the staff present to support them. Residents indicated that inspectors were welcome into their

apartments and on the second day when one resident indicated that they did not wish to engage further, this was respected.

Residents were supported to keep in touch with, and spend time with their family and friends if they wished to. There were numerous areas of their apartments where residents could spend time with their family and friends in private. Residents' personal plans included regular outings with family or friends and opportunities for meals out or shared take away meals. To the front of the premises were large planted flower pots and some of these were personalised to individuals. Two residents in particular used and enjoyed growing things in the poly tunnel. Residents families told inspectors they were very happy with the service and visited regularly and found staff and management excellent.

In summary, residents appeared relaxed and content in their home and with the levels of support offered by staff. They were supported to decorate their apartment in line with their preferences, and had increased opportunities to take part in activities they found meaningful. They were supported by regular staff who were were familiar with their needs and preferences.

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 findings of this inspection were that the residents were in receipt of a good quality safe service. The provider was monitoring the quality of care and support residents received and working to support them to gain independence and make choices that were meaningful.

The centre was for the most part well run as the provider and person in charge systems were proving effective at capturing areas where improvements were required, and bringing about these improvements. While improvements were required in areas as stated above in staffing arrangements, risks associated with staffing levels and the management of personal possessions these are outlined in detail against the specific Regulations.

The provider had a management team in place with clear lines of authority and accountability identified. Due to unexpected leave there was a change to the management team required on the day of inspection. The provider was implementing their governance contingency plan to ensure there were oversight arrangements in place. The provider had systems in place to monitor care and support including audits, the six-monthly and annual reviews, and resident and

family surveys.

The centre was not however, adequately resourced and while 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 the gaps in staffing at times led to increased risks for residents and a higher use of restrictive practices. For example, at night time.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted all of the required information with the application to renew the registration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had not ensured that the current staffing arrangements at the designated centre were appropriate to support and meet the residents' assessed needs. The inspectors found that the designated centre required additional staff resources in the evening and at night to adequately support and meet the residents' assessed needs.

Residents were supported on a one to one basis by day however, from shift change time (eight or nine at night) only one staff between two residents was available. Inspectors found that there were increased numbers of incidents during this time and an increased use of restrictive practices such as locked doors and listening alarms to compensate for the reduced staffing levels.

Inspectors found that there was no clear guidance for staff on how often they should move between apartments. Where one resident was assessed for funded additional hours and another resident not funded for additional hours it was not apparent how these were allocated.

In addition, the registered provider was found to be rostering fewer staff members during weekends, which had an adverse impact on the residents' support and assessed needs.There was a continued reliance on the use of agency and relief staff members to supplement the core staff team.

A review of staff duty rosters found that actual and planned rosters were maintained. However, some of the planned rosters in place were missing details, such as the full names or titles of staff.

Judgment: Not compliant

Regulation 16: Training and staff development

The registered provider had a training matrix in place, and the inspectors found that all staff had been provided with mandatory training in safeguarding, food safety, fire safety, first aid, positive behaviour support, the safe administration of medication, manual and patient handling. Refresher training had been scheduled for staff when required.

Staff were also in receipt of training that was specific to individual residents needs. This ensured that the staff on duty could provide safe care in line with individual assessed needs.

The person in charge had a staff supervision plan in place and all staff were in receipt of formal support and supervision in line with the provider's policy. Supplemental supervision and on the job support was also used as required.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured that records specified in Schedules 2 of the regulations were maintained and available for the inspector to review.

Judgment: Compliant

Regulation 23: Governance and management

This inspection was facilitated by members of the management team and members of the centre staff team as the person in charge was on leave. The provider had ensured that there were clear lines of accountability and authority in place and the staff were clear on who they reported to. There were clear summary documents in place to manage any changes in the centre management team and the inspectors found that the provider had contingency arrangements in place to manage staff changes. Overall the provider had demonstrated improved levels of oversight and management of this centre despite a number of personnel changes.

The provider had completed audits as required by the Regulation including six monthly unannounced audits and an annual review, the person in charge had devised action plans based on these audits. Centre based audits and reviews were

also occurring that monitored the provision of care and support. In the area of financial review however, these audits were found to require improvement as they were not consistently identifying areas that required action.

The provider was not ensuring that the centre was fully resourced to provide care and support assessed as required for all residents as has been outlined under Regulation 15. In addition, the inspectors found that the management of data present in the centre required review. Locating specific information that may be required to support the staff team in carrying out their role was challenging with large volumes of information present, pertinent information not always stored where expected, duplication of information present and inaccurate or outdated information present.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose is an important governance document that outlines the service to be provided in the centre, in addition to outlining the model of care and support that is delivered to residents. The inspectors found that the centre statement of purpose, which had been submitted in advance of the inspection as part of the registration renewal application, contained all areas as required under Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider has a system in place for the recording and oversight of incidents and significant events within the centre. This ensured that incidents were reviewed by the person in charge and relevant professionals which allowed for them to be notified as required. The inspectors reviewed the accident and incident system and found that all that required it, had been submitted to the Chief Inspector of social services within the time frame as outlined in the Regulation.

Judgment: Compliant

Quality and safety

Residents were found to be safe, well cared for and had a good quality of life in this

centre.

The inspectors found that the provider and person in charge were endeavouring to ensure that the well-being and welfare of the residents was maintained to a good standard. The person in charge and staff were aware of residents' needs and knowledgeable in the care practices to meet those needs.

Care and support provided to the residents was of good quality although as already outlined this was on occasion reduced as a direct result of staffing levels. On the day of the inspection, to ensure the safety of residents at all the times, some improvements were needed to the risk identification and management systems and practices that were in place. In addition, improvement in the protection and oversight of finances and personal possessions was required.

The person in charge and staff were found to have facilitated a supportive environment which enabled the residents to feel safe and protected from all forms of abuse. All staff had received training in safeguarding. Overall, the inspectors found that the residents were protected by practices that promoted their safety.

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 in addition to challenges for residents in engaging with financial institutions. Access to finances have to be requested through the main central office. Staff in the main office are only available during office hours, this means that expenditure has to be planned in advance as access to resident monies after these hours was limited. The provider had identified the limitations of the types of accounts in place and has taken some action to try and rectify this, this is an area that continues to require review.

The provider had completed reviews of their financial oversight systems over the course of this year. While inspectors acknowledge that some improvements had been made, they required further review to consistently protect residents' possessions.

For example, resident account statements had not been available since June 2023 and this did not allow for reconciliation of expenditure or overview of income. In addition, while items were recorded as having been purchased for individuals these were not reflected on residents possession lists for all individuals. Inspectors found that not all residents had possession lists and where they were present they were not consistently updated.

Improvement was required in the recording of details against expenditure to allow for oversight, for example there was a record of one resident having met with staff on 02 February to purchase a large item for the garden with a stated cost of €950, however, this record was not accurate. There were records of spending by a resident while on holiday abroad however, it was expenditure by a staff member

that was reimbursed by the resident. Currency cards had been purchased for residents so they could 'tap' for purchases but not all staff were familiar in the use of same or how the reconciliation of account balance worked.

While improvements have been made in this area, a clearer and more accurate standard of recording and consistent application was required regarding all aspects of residents finances.

Judgment: Not compliant

Regulation 13: General welfare and development

Residents were observed to have a good quality of life and good levels of activation. Residents spoke to the inspectors about going into the community, going mountain climbing, to the gym, to the cinema, out for meals and to the local men's shed. One resident has a small business cutting grass and residents are involved in social farming.

Residents were met in their apartments and were proud of their home showing inspectors pictures and discussing activities that they enjoyed. Each apartment was found to be warm and homely and residents had personal items of interest available to them such as jigsaws, woodwork tools or computers. Residents told inspectors they were looking forward to a 'Winter Wonderland' event being run by the provider in a local GAA Hall for Christmas. Overall residents were very happy and presented as having a good quality of life.

Judgment: Compliant

Regulation 17: Premises

Overall the inspectors found that the design and layout of the premises was suitable to meet the individual and collective needs of the residents. Significant work to the premises had been completed since the previous inspection in line with the providers' stated actions as submitted to the Chief Inspector in their compliance plan.

Each resident had their own individual apartment and the staff worked with residents to ensure that the premises decor was reflective of each specific individual likes and interests. The physical environment of the premises was clean and well maintained. The provider was in the process of completing some bathroom upgrades and had replaced flooring and some furniture since the last inspection.

The provider has systems in place for the ongoing review of the premises and had identified areas that required replacement or review on an ongoing basis. The

creation of the fourth apartment had encompassed previously un-used areas within the premises and these changes had been positive in how the building was used.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were for the most part protected by policies, procedures and practices relating to health and safety and risk management. The person in charge ensured that there was a risk register which they reviewed regularly. General and individual risk assessments were developed and there was evidence that they were for the most part reviewed regularly and amended as necessary. Some of the centre based risks reviewed were still based on occupancy levels of three residents and not four.

It was of concern however, that the risks associated with being on their own without staff support were not clearly identified and assessed for. As a result no control measures were in place that provided guidance for staff on the frequency of support that should be in place when a single staff member was working between two apartments. For one resident for instance there was a risk identified of burns and scalds when cooking, where the identified control measure was close supervision. The inspectors found that the resident had been involved in a number of incidents relating to overeating and food access when without supervision and no control measures or assessment of the risks regarding access to the kitchen when no staff were present had been completed for example.

Judgment: Not compliant

Regulation 28: Fire precautions

This was an area that the provider had prioritised as requiring action since the previous inspection. The provider had assessed the premises and had completed actions identified as required.

Suitable fire equipment was available and there were systems in place to make sure it was maintained and being regularly serviced. There were adequate means of escape and emergency lighting was also present.

The centre evacuation plans were current and regularly reviewed. Each resident had a personal emergency evacuation plan outlining any supports they may require to safely evacuate the centre in the event of an emergency. Some plans required further detail in line with the findings as outlined under Regulation 15 and 26. One plan for example stated that 'my staff are in another apartment but check on me regularly' however, staff were not clear on how often they should check or if they

checked after 22:00. Fire drills were occurring regularly in the centre and staff had completed training to ensure they were aware of their roles and responsibilities in the event of an emergency.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The residents had an assessment of need and personal plans in place.Plans that related to personal care and to social goals were comprehensive in nature. They detailed the resource requirements to maximise residents personal development and quality of life. For example, staff support or access to activities such as recreation facilities.

Residents' health and social care needs were developed through a person-centred approach with attempts to involve the residents at each stage of planning.There was evidence that plans made were person centred and took individuals aspirations and wishes into account. Residents were engaged in activities such as cold water swimming, hill walking, cycling, or gardening.

Judgment: Compliant

Regulation 6: Health care

Residents enjoyed good levels of general health and presented as well cared for. Up to date health care reviews, health checks and hospital passports were reviewed. Inspectors found that residents had regular access to G.P., Psychology, Psychiatry, Behavioural Support, Dental, Nurse, Opticians/Eye Health, Dietician, etc. Staff on duty demonstrated very good knowledge and awareness of the residents in their care in terms of their healthcare needs. Families told inspectors that residents were always supported to live healthy lives and were well supported in the centre in terms of their physical and mental health and well being.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider promoted a positive approach in responding to behaviours that challenge and staff had attended training in de-escalation and intervention. Residents had positive behaviour support plans in place and streamlined support

plans had recently been reviewed. These clearly guided staff to support individuals to manage their behaviour. The person in charge had ensured that residents attended specialist appointments and that findings from these were incorporated into the resident's personal plans.

There were a number of restrictive practices in operation in the centre to promote the safety of residents which included the use of monitors, locked doors and fluid restrictions. These were found to have been assessed and were subject to regular review. The provider also facilitated a restrictive practice review meeting that also provided oversight and review of all restrictive practices in place. As reflected against Regulation 15 there was some evidence that restrictions were being utilised to manage behaviours in the absence of staff support such as over-eating or doors locked to prevent property destruction when staff were not present.

Judgment: Compliant

Regulation 8: Protection

The provider and person in charge had ensured that residents were protected for the most part by the policies, procedures and practices relating to safeguarding and protection in place. Notwithstanding improvements required in relation to financial safeguarding as outlined under Regulation 12.

Safeguarding plans if required were developed and reviewed. Staff had completed training in relation to safeguarding and protection, and those who spoke with the inspectors were knowledgeable in relation to their roles and responsibilities. The inspectors reviewed a number of residents' intimate care plans and found they were detailed, attached to an appropriate personal care plan and guiding staff practice in supporting residents.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that residents were supported to make decisions in their day to day lives. The physical changes in the centre, such as addition of a new apartment and the use of the poly tunnel had ensured that residents privacy and dignity were promoted. In addition there was evidence that independence skills were promoted whenever possible.

Resident's consent was sought through the use of easy read and symbol supported forms. All those who lived in the centre met on a regular basis with key staff to discuss matters important to them and to decide on the organisation of their home.

There was evidence that residents were provided with information regarding their rights as part of these meetings
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Damara OSV-0003446

Inspection ID: MON-0033034

Date of inspection: 20/11/2023 and 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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • PIC will review present staffing standard in house with DOS & ADOS to ascertain if they meet the assessed needs of people supported in designated centre. (By 10.01.2024) • PIC will review use of agency staff in the centre over last 3 months and discuss future planning with DOS & ADOS (By 10.01.2024) • Following review of staffing standard, the PIC will review the roster to ensure it supports the assessed needs of people supported. (By 19.01.2024) • PIC will review risk assessments, SOP & support plans, paying attention to different staffing levels that might be rostered on at different times. • PIC to add Risk assessments & SOP on the agenda of team meetings for discussion and signed off on by all staff (By 29.02.2024)	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • PIC will circulate the Data Retention & Destruction Policy to all staff to read and sign off on. • PIC will discuss Data Retention & Destruction Policy at January'24 team meeting to ensure all staff understand how to implement (By 30.01.2024) • PIC complete a full data cleanse of all files in the centre (By 23.02.2024) • PIC will review present staffing standard in house with DOS & ADOS to ascertain if they meet the assessed needs of people supported in designated center. (By 10.01.2024)	

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

• Finance will roll out of person supported Soldo cards in January 2024. This will facilitate up to date statements for each person's spending 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.

• PIC will circulate the updated Finance Policy and team read and sign off on their understanding of it, to include new Sold cards (By 02.02.2024).

• PIC will link with QA department to plan training for full staff team on Finance policy, to include gaining the knowledge and skills to complete documentation. (By 30.01.2024)

• PIC to complete monthly finance audits ensuring oversight on house and person's spendings.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

PIC will take the following actions,

• Review and update center-based risk assessments (By 12.01.2023)

• PIC will review and update person supported risk assessments, SOP & support plans, taking into consideration staffing levels that might be rostered on at different times. (27.01.2024)

• PIC to add Risk assessments & SOP on the agenda of team meetings for discussion and signed off on by all staff (By 29.03.2024)

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.	Not Compliant	Orange	13/01/2024
Regulation 15(4)	The person in charge shall	Not Compliant	Orange	13/01/2024

	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.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	20/01/2024
Regulation 23(1)(c)	The registered provider shall 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.	Substantially Compliant	Yellow	28/02/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	27/01/2024