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:	The Haven
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	17 January 2024
Centre ID:	OSV-0005236
Fieldwork ID:	MON-0033624

About the designated centre

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

The Haven is located in a rural area of County Kildare and provides 24-hour residential supports to five adults with an intellectual disability. The centre consists of a large two-storey house with an adjacent self-contained single apartment. In the main house the ground floor consists of a kitchen, utility area, living room, sitting room and bathroom and four bedrooms, one of which is the staff sleepover room/office, with another two bedrooms and a bathroom upstairs. There is also a staff office and games room/staff sleepover room. The apartment contains a kitchen-dining room, a sitting room, a sensory room, bedroom and large bathroom. There is also a garden for recreational use and spacious grounds surrounding the house and apartment. The staff team is made up of social care workers, assistant social care workers, deputy managers, and a person in charge. Nursing input is available as needed from a nurse employed in the wider organisation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 17 January 2024	10:30hrs to 17:30hrs	Gearoid Harrahill	Lead
Wednesday 17 January 2024	10:30hrs to 17:30hrs	Maureen Burns Rees	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet with the residents in the designated centre and observe some of their day, as well as speak with their direct support staff and review documentary evidence of their support plans, personal goals and feedback on their support, as part of the evidence indicating their experiences living in The Haven. This inspection was announced in advance and the provider indicated that residents had been made aware that a visit would be taking place in their home.

Four residents lived in a large countryside house with one resident having their own single-occupancy apartment annexe. Each resident had their own private bedroom with adequate space to decorate or personalise their rooms. Residents had access to large living rooms, kitchen and dining spaces. The house overall was bright, clean, tidy and appropriately maintained. Residents were supported to decorate their bedrooms as they preferred, and the staff were currently working on strategies to support one resident to sleep in their bedroom instead of communal spaces for use by others. Residents were observed accessing their kitchen space either alone or with staff support to get snacks and prepare meals.

On arrival to the house, inspectors observed that all residents were out for the day at medical appointments, day support services and community outings. Later in the afternoon residents arrived home and were supported to follow their preferred routine, having lunch or relaxing in their privates spaces. The residents were engaging in enjoyable activities outside the house, including going out to lunch, swimming, day services and social clubs. One resident enjoyed watching planes at the airport, and another resident was engaged in a voluntary job one day a week. For the most part, residents engaged in their routines separately with one or two staff allocated, though staff indicated some success with residents doing things together at home or in the community. Inspectors discussed with staff the potential constraints where residents required one staff support to travel but two staff to leave the vehicle when in the community, and how this was being mitigated to ensure residents had optimal choice in their separate routines.

Inspectors spoke with staff members delivering direct support to residents. In the main, staff indicated that there had been a sustained improvement in residents being active and engaged with meaningful and enjoyable outings and activities, which in turn had had a positive impact on sleep quality and healthy daily routine. Staff indicated that while there remained risk related to the relationship and interactions between residents sharing their home, the level of engagement with personal routines in and out of the house had contributed to there being fewer incidents in which residents were engaged in negative interactions with each other. Where trends or incidents of concern had continued, the provider had commenced formal assessment to determine if the benefits to some residents sharing the house with particular peers outweighed the potential risk of harm of distress.

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 on the quality and safety of the service being delivered.

Capacity and capability

This announced inspection was carried out to monitor the provider's regulatory compliance, to inform a decision on the provider's application to renew the registration of this designated centre. Inspectors overall found that improvements in regulatory compliance had been sustained by the provider, and internal audits and quality reviews were taking place to ensure that the service was equipped to support the needs of service users and take timely action where improvement was required.

The provider had demonstrated continued improvement with regard to residents being actively engaged with day services, recreational activities and work opportunities. While still an active risk, there had been a reduction in the frequency of peer-to-peer incidents between residents.

The service was staffed by a team of social care personnel, and a house management team which facilitated effective deputation and staff support. Staff who were available to speak with inspectors demonstrated an overall good understanding of their duties and responsibilities in their respective roles, and commented positively on the support of their colleagues and managers.

In the main, the findings of the provider internally though audits and service reviews were specific and measurable, and it was clear how the provider was using information attained through routine checks to identify and address errors or information gaps, such as with medicines, health monitoring, finances and resident goals.

Regulation 14: Persons in charge

The person in charge worked in this designated centre full-time. They were appropriately experienced and qualified in the management and leadership in a social care setting.

Judgment: Compliant

Regulation 15: Staffing

At the time of this inspection, the designated centre had a full complement of staff. Worked staffing rosters clearly identified who had been working in the centre and when staff were being covered during absences. Rosters also clearly identified who was leading the staff team each day.

Judgment: Compliant

Regulation 21: Records

Inspectors reviewed a sample of records required by regulations. Review was required to provide assurance that records were accurate and properly maintained, including records related to resident supports and staff supervision.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had conducted an unannounced quality and safety inspection of the designated centre in January 2024, the report of which was comprehensive and detailed in the findings and actions required in the service's compliance with regulations and best practice, and adherence to provider policy and procedure. The provider had identified a need to improve how these reports reflected on the quality of life, experiences and feedback of residents or their representatives beyond observations made on the day of the audit. The actions coming from this six-monthly inspection were clearly set out and allocated to the responsible person with target times to address same, including matters related to staff knowledge, ongoing review of residents' support plans, complete record-keeping, and protection of residents.

The provider had published their annual report for this designated centre in October 2023, which told a story of what it was like to live in this house and what the residents were doing or had achieved in the preceding year. This included commentary related to residents' success or future plans in pursuing hobbies and work experience.

In the main, inspectors observed evidence to indicate that the provider had improved in their overall regulatory compliance, and had sustained their improvement actions and oversight measures which were implemented following service deficits and risks identified on previous inspections in 2022 and 2023.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had updated their statement of purpose in January 2024 to reflect current information in the designated centre as required by this regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had notified the Chief Inspector of events and practices in the designated centre within the requisite timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors observed evidence to indicate that complaints received in or about the designated centre had been appropriately responded to, with records of debrief sessions with the complainant and other relevant persons on the outcome and actions being taken.

Judgment: Compliant

Quality and safety

In the main, each resident's wellbeing and welfare was maintained by a good standard of evidence-based care and support. Support was directed by guidance with which staff were familiar, and to which they had contributed based on working with service users and knowing their preferences, presentations and risks. Health action plans were in place for residents identified to require same.

Residents were observed to be appropriately supported with activities of daily living, having meals and communicating with others by a team of staff who were knowledgeable on their assessed needs. Staff were familiar with how to avoid or to deescalate instances of heightened anxiety or aggression. Staff were observed to be

ensuring that residents had a varied and meaningful level of engagement at home and in the community, and gave examples of where that had been successful or had been affected by challenges.

Some improvements were required in the record-keeping and oversight of finances, medicines, restrictive practices and progression of personal goals, however the provider had identified similar findings in their own audits and had identified actions to improve same. The provider had also committed to enhancing focus on residents' rights, particularly in areas such as access to money, consultation on decision making, mitigation of the impact of risk control measures, creating versions of documents with which residents could engage, and capturing meaningful commentary for use in service reviews.

There were measures in place to protect residents from being harmed or suffering from abuse. However, the behaviours of a number of the residents were on occasions difficult for staff to manage in a group living environment. This had the potential to be a safeguarding concern and to have a negative impact on the other residents in the centre but generally incidents were well managed. It was noted that allegations or suspicions of abuse had been appropriately reported and responded to. The provider had a safeguarding policy in place. Individual work had been completed with some of the residents regarding how to keep themselves safe. Staff members spoken with, were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. Staff had attended appropriate training. Intimate care plans were on file for each of the residents and these provided sufficient detail to guide staff in meeting the intimate care needs of the individual residents.

Regulation 10: Communication

There was a policy on communication in effect, and individual communication requirements were highlighted in residents' personal plans and reflected in practice. Communication passports were on file for residents who required them. Staff were observed to respond appropriately to residents' non-verbal prompts in a dignified manner. There were communication tools, such as picture exchange and objects of interest in place, to assist residents to choose their food, activities, daily routines and journey destinations.

Judgment: Compliant

Regulation 12: Personal possessions

At the time of this inspection, three out of five residents in this designated centre did not have accounts with financial institutions into which they could receive their

income. These residents were not facilitated to optimally control and access their money, either independently or with the support of their direct care staff. For residents who had cash and cards belonging to them in the centre, these were locked in a staff office, and while the person in charge advised that some residents had capacity to develop their understanding and skills at using them, there was limited evidence of plans to support residents to readily access their property.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Specific personal, social and recreational goals were identified for residents. Records were maintained of session planning to achieve goals such as residents attending seasonal events, funfairs and opportunities to travel, however in some cases records to show if residents had achieved their identified goal were not well maintained. There were monthly outcome sheets with identified actions to achieve.

Inspectors discussed with staff examples of when residents who required two staff to support community engagement would go out with one staff and as such be limited in their choices of what to do while out. There was limited evidence to indicate how the provider was assured that this was being formally assessed and the potential impact on choices and rights mitigated.

Judgment: Substantially compliant

Regulation 17: Premises

The inspectors observed a substantial improvement in the general cleanliness of the designated centre following the findings of previous inspections. Bedroom, bathroom, kitchen and outdoor areas were overall clean and in a good state of maintenance. The inspectors observed examples of a bedroom belonging to a new resident having been redecorated as they preferred.

Judgment: Compliant

Regulation 26: Risk management procedures

The health and safety of residents, visitors and staff was promoted and protected. Environmental and individual risk assessments and safety assessments were on file which had been recently reviewed. There were arrangements in place for

investigating and learning from incidents and adverse events involving the residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to ensure the safe management and administration of medicines. The processes in place for the ordering, receipt, prescribing, storage and administration of medicines was found to be appropriate. All staff had received training in the safe administration of medicines. Assessments had been completed to assess the ability of individual residents to manage and administer their own medicines. However, none of the residents were deemed to have capacity to manage their own medicines, and medication management plans were in place. There were some systems in place to review and monitor safe medication management practices. A team leader in the centre was the identified medications officer and responsible for oversight of medication management arrangements. Regular checks and counts were taken of medication practices.

There was a medication error pathway but overall noted low number of medication errors in the centre. There were procedures for the handling and disposal of unused and out of date drugs. A record was maintained of all unused and out of date medications returned to pharmacy. However, it was noted that this record was signed by two staff from the centre, but the receiving pharmacist did not sign to acknowledge receipt of the medication in line with best practice in this area.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their quality of life in accordance with their individual health, personal and social care needs and choices. Records of personal plan annual reviews were in place.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional and behavioural support and their assessed needs were appropriately responded to. Positive behaviour support

plans were in place for residents identified to require same. These had been reviewed by the provider's behaviour consultant. The plans put in place provided a good level of detail to guide staff in meeting the needs of the individual residents. There was a policy on the provision of behaviour support and staff had received appropriate training.

A register was maintained of restrictive practices used in the centre and these were subject to regular review. For a number of these practices there was evidence that alternative measures were considered, as part of reduction plans in place for residents and their assessed level of risk. However, in the case of some restrictive practices, there was limited evidence observed that they had been introduced or retained based on the assessed risks for those affected by the practice. For example, some restrictions were implemented in a blanket fashion to all people living in the centre. Other restrictions had not been assessed for how they impacted on the rights of the resident for whom the practice was introduced, nor for other residents who were secondarily affected by the measures.

Judgment: Substantially compliant

Regulation 8: Protection

Staff members were trained in safeguarding of adults at risk of abuse, and were knowledgeable on identifying and reporting instances in which there was witnessed or suspected abuse of residents. Incidents of safeguarding concern were being reported to the Designated Officer and Health Service Executive Safeguarding and Protection Team as required.

There had been an identified trend of incidents in which residents were at risk due to interactions and presentations of their peers. In response to this, the provider had commenced a formal assessment to determine whether combinations of service users were compatible in their current living arrangements. The inspectors observed that the provider had summarised the pattern and history of incidents causing concern.

The inspectors reviewed a sample of how the staff were protecting the residents' finances, and in the main the records of spending matched bank statements visible to the staff. However improvement was required in the records of one form of income so that staff could be assured of how much belonged to one resident in the house. As referenced elsewhere in this report, staff did not have access to records to carry out protective checks that all residents' personal income and spending was accounted for.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The provider had a food safety policy and a monitoring and recording of nutritional intake policy in effect. Inspectors observed evidence that each of the residents had a regular review with a dietitian. Residents individually decided on their own menus for the week and prepared their own meals with the support of a staff member on occasions. It was noted that a variety of healthy, nutritious and appetising meals were prepared in the centre.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 18: Food and nutrition	Compliant

Compliance Plan for The Haven OSV-0005236

Inspection ID: MON-0033624

Date of inspection: 17/01/2024

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. The Person in Charge (PIC) shall complete a review of all staff supervision records in the Centre in line with Nua's policy and procedure on supervision [PL-OPS-017]. Completed: 29 February 2024 2. The PIC shall complete a review of all Individuals direct support hours within their Comprehensive Needs Assessments (CNA's) to ensure these are in line with their assessed needs. Due Date: 28 March 2024. 3. All the above points shall be discussed with all Team Members by the PIC at the next monthly team meeting. Due Date: 29 March 2024	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: 1. The Person in Charge (PIC) shall continue to collaborate with all relevant stakeholders to support Individuals, where required in directly receiving their disability income into a personal bank account with the Individuals as the sole signatory on the account. Due Date: 29 March 2024 2. Whilst all Individuals insofar as reasonably practicable, have access to their finances, where necessary, the PIC shall ensure support is provided by the Centre to manage and	

safeguard their financial affairs in line with the Centre's policy and procedure on Safeguarding of Vulnerable Persons [PL-C-001] as well as ensuring relevant financial statements are maintained on file to effectively manage and monitor their account balance in line with Nua's customer control policy and procedure [PL-F-002].
Due Date: 29 March 2024

3. The PIC in conjunction with the Director of Operations will develop and maintain a folder of evidence to demonstrate on-going communications with HSE and Family Members regarding relevant Individuals obtaining full financial control over their finances in line with Assisted Decision Making and Capacity act 2015.

Due Date: 29 March 2024

1. All the above points shall be discussed with all Team Members by the PIC at the next monthly team meeting held on 29 March 2024.
Due Date: 29 March 2024

4. Nua's Quality Assurance Team shall complete a full review of documentation and evidence of all correspondence with stakeholders as well as conducting a review of all Individuals monies, ledgers and financial statements so as to ensure the Centre demonstrates insofar as is practicable, compliance in line with Nua's policies and procedure on customer control [PL-F-002] as well as all necessary steps taken with all relevant stakeholders to ensure relevant Individuals have full access and control to their financial affairs where required.

Due Date: 11 April 2024.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
1. The Person in Charge (PIC) will complete a review of all Individuals monthly outcomes to ensure SMART goals are in place, where required.

Due Date: 28 March 2024

2. The PIC shall complete a review of all Individuals direct support hours within their Comprehensive Needs Assessments (CNA's) to ensure these are in line with their assessed needs.
Due Date: 28 March 2024

3. All the above points shall be discussed with all Team Members by the PIC at the next monthly team meeting.
Due Date: 29 March 2024

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. There are systems in place to ensure the receiving pharmacist signs all medication returned to the dispenser. The Person in Charge (PIC) will continue to manage and monitor these systems in line with Nua's policy and procedure on safe administration of medication practices [PL-C-010].

Completed: 28 February 2024

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The Person in Charge (PIC) in conjunction with the Centre's Behavioral Specialist shall complete a further review of all restrictive practices. Following this review The Director of Operations (DOO) and Behavioral Specialist Manager shall review and approve any actions arising out of the restrictive practices review.
Due Date: 28 March 2024

2. The PIC shall ensure a Communication Passport is implemented for all Individuals in The Haven to support them with understanding the current restrictions relevant to them and gaining their consent, where appropriate, with all restrictions implemented.

Due Date: 29 March 2024

3. All the above points shall be discussed with all Team Members by the PIC at the next monthly team meeting.
Due Date: 29 March 2024

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Person in Charge shall ensure support is provided as necessary by the Centre to manage and safeguard their financial affairs in line with the Centre's policy and procedure on Safeguarding of Vulnerable Persons [PL-C-001].

Note: The recording balance of the Individuals disability allowance was completed on the day of the inspection by the Person in Charge (PIC). There are appropriate systems in place for the PIC to monitor Individuals finances in line with Nua's policy and procedure on customer control [Pl-F-002].
Completed: 15 January 2024

2. The Person in Charge (PIC) shall continue to collaborate with all relevant stakeholders to support Individuals, where required in directly receiving their disability income into a personal bank account with the Individuals as the sole signatory on the account.
Due Date: 07 April 2024

3. Whilst all Individuals insofar as reasonably practicable, have access to their finances, where necessary, the PIC shall ensure support is provided by the Centre to manage and safeguard their financial affairs in line with the Centre's policy and procedure on Safeguarding of Vulnerable Persons [PL-C-001] as well as ensuring relevant financial statements are maintained on file to effectively manage and monitor their account balance in line with Nua's customer control policy and procedure [PL-F-002].
Due Date: 29 March 2024

4. The PIC in conjunction with the Director of Operations will develop and maintain a folder of evidence to demonstrate on-going communications with HSE and Family Members regarding relevant Individuals obtaining full financial control over their finances in line with Assisted Decision Making and Capacity act 2015.

Due Date: 29 March 2024

5. All the above points shall be discussed with all Team Members by the PIC at the next monthly team meeting held on 29 March 2024.
Due Date: 29 March 2024

6. Nua's Quality Assurance Team shall complete a full review of documentation and evidence of all correspondence with stakeholders as well as conducting a review of all Individuals monies, ledgers and financial statements so as to ensure the Centre demonstrates insofar as is practicable, compliance in line with Nua's policies and procedure on customer control [PL-F-002] as well as all necessary steps taken with all relevant stakeholders to ensure relevant Individuals have full access and control to their financial affairs where required.

Due Date: 11 April 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.	Substantially Compliant	Yellow	11/04/2024
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	29/03/2024
Regulation 13(2)(c)	The registered provider shall provide the following for	Substantially Compliant	Yellow	29/03/2024

	residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	29/03/2024
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	29/03/2024
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal	Substantially Compliant	Yellow	28/02/2024

	products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	29/03/2024
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	29/03/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	29/03/2024