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:	Glen 2
Name of provider:	Avista CLG
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	27 October 2023
Centre ID:	OSV-0001439
Fieldwork ID:	MON-0034795

About the designated centre

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

Glen 2 is a campus-based residential centre which provides full-time care and support for 18 residents with moderate to severe intellectual disability and/or a physical disability. Each of the three purpose built bungalows in the centre have the capacity for six residents. Each bungalow is homely and comfortable and each of the residents have their own bedroom which is decorated in line with their wishes. The centre is situated on the outskirts of Dublin City, close to a local village with access to local amenities such as a pub and restaurant within walking distance, a large park and local shopping centres. Residents have access to a number of vehicles to access their local community and leisure activities. Two of the houses are nurse led and one is a social care led house. Residents are supported by staff in the centre 24 hours a day, seven days a week.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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
Friday 27 October 2023	10:30hrs to 17:00hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

Glen 2 is a congregated-based designated centre which provides full-time care and support for 18 residents with intellectual disabilities. The campus, while located in a green space on the outskirts of Dublin City, does not have close links to public transport, and therefore, residents rely on transport attached to the designated centre and campus. The campus contains nine purpose-built bungalows for a total of 52 residents, a day service, administration offices, a quiet reflection room and a restaurant.

Glen 2 contains three bungalows, which is registered for a maximum of 18 residents. On the day of the inspection, 17 residents were living in the centre with one vacancy. The purpose of this unannounced monitoring inspection was to assess the registered provider's ongoing compliance with the regulations. While the centre consisted of three bungalows, the inspection focused on one bungalow due to a trend in safeguarding notifications submitted for this group of six residents. Information contained within the notifications indicated there was a negative impact on five residents when one resident became unwell. The provider had outlined measures they had taken to safeguard residents, including increasing staffing hours during the hours of 8pm to 10pm and the resident causing concern being reviewed by a clinical nurse specialist (CNS) in behaviours of concern; however, the inspector found these did not fully address the ongoing compatibility concerns in this bungalow.

On arrival at the bungalow, one resident was leaving with a staff member to go to their place of work; this resident was in paid employment locally. The inspector spent a short of period of time in the house speaking with two residents who were sitting in the dining and living room. One resident was engaging in a tabletop activity and requested the inspector to join them. The second resident was watching television. Two staff members were working in the bungalow and assisting other residents with their morning routines in their bedrooms. While both residents appeared happy to meet with the residents, the inspector observed residents express signs of anxiety and make repeated and conflicting demands of staff.

Each bungalow can accommodate six residents, with each resident having their own bedroom. There is an open plan combined dining, living and kitchen area and a separate small sitting room. In addition, there are two shower rooms, one bathroom, a staff office, a staff locker room and changing area with showering facilities, and a laundry room. The attic space, which was used as storage space, could be accessed via a flight of stairs.

The inspector asked the residents what their plans were for the day, and some were going to an art class in the day service building after lunch. Two staff members were supporting four residents. One resident made comments requesting to leave the centre to go to another place of interest on campus; this activity was not facilitated during the inspectors time in the centre. Upon review of rosters, two staff members

were rostered each day to work in each bungalow for six residents. It was not demonstrated that this provided adequate support to facilitate one-to-one activities. For example, the inspector viewed records of staff trying to organise an outing for one resident, but it required additional staff support from day services.

While staff tried to reassure and attend to residents' needs in a sensitive manner, the inspector observed some behaviours increase and escalate and moved from the living space to the office to meet with the person in charge and the newly appointed campus service manager who had arrived at the centre. Staff had engaged the resident in a recycling activity in the centre, and the resident appeared to enjoy this activity whilst welcoming members of management into their home. The resident requested several times to visit the administration building on campus, and management made arrangements for a visit later in the week. At this point in the inspection, the inspector made a decision to hold discussions with management at another location on campus to limit any negative impact on residents and the presence of other people in their homes.

The provider's annual review for 2022 included a visit to the centre over two days in order to meet with all residents to gain an understanding of residents' views and lived experiences. The review also identified that for some residents, their access to activities outside of campus was not as frequent as other residents. Feedback from residents who were supported to complete surveys for this review highlighted that some residents would like more day activities and more access to the community, and one resident said they would like to move into the community. One resident expressed an interest in obtaining employment and was, at the time of the review, working on a CV and reviewing work opportunities with a supported employment coordinator. The inspector learned that this resident had since gained employment, which they were happy about.

Family representatives also were consulted with for their feedback on the quality of the service being provided to their family members. In total, 12 families returned surveys to the provider; overall feedback was generally positive, and families were satisfied with the quality of care. Families commented that the staff knew the residents well and were welcoming to families. One family commented on the staffing levels, the need for more activities and the use of unfamiliar agency staff in the centre. Another family expressed reservations in relation to plans for community living.

The inspector reviewed the restrictive practices in place in the centre. A magnet swipe system operated all front doors to the bungalow. The stated rationale for this restriction was general security and a risk to residents' safety due to a lack of road safety awareness. Some residents were also at risk of leaving their homes without support from staff. Previous trials of leaving doors open for a period of time have been unsuccessful due to residents leaving their homes without support from staff. While in this house, the swipe door was unlocked during daytime hours. The inspector observed that a resident was restricted from leaving the centre as they could not leave the centre without staff support.

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 to each resident living in the centre.

Capacity and capability

Previous inspections carried out on the campus found ongoing concerns regarding the continuity of staffing levels, compatibility of residents living together and the capacity of the provider to implement actions as identified through various quality improvement audits and reviews. This inspection found similar issues, but the provider recently implemented increased governance structures within the centre to address oversight and monitoring decisions. The inspector acknowledged these improvements and that they required time to be incorporated into the centre and impact quality initiatives and change.

The campus governance structure included the oversight of a service manager. The inspector met with the newly appointed service manager, who had been in the post for three weeks. While new to the organisation, the service manager had already begun to review areas for improvement, including outstanding compliance actions, residents' finances and rosters. The inspector found they were responsive to the regulatory and inspection process and motivated to improve campus compliance and quality outcomes for residents.

The service manager was supported by a clinical nurse manager grade 3 (CMN3), who was the reporting manager for the three persons in charge of the three designated centres. On-call clinical and managerial support at night time was provided through the clinical nurse manager grade 2 (CNM2) based in another campus-based setting operated by the provider. The inspector was informed the provider was increasing night support within the campus by employing two night time managers who were currently going through the induction process. This would allow for increased in-person support for staff and residents as well as auditing and monitoring oversight.

However, additional improvement was required at the centre level to ensure adequate management systems were in place to support the capacity of the person in charge. For instance, the governance structure of the centre, as documented in the statement of purpose, details the person in charge as having the support of two clinical nurse managers grade one (CNM1). The inspector learned one of these posts was vacant for more than a year, and the status of this vacant position was unknown during the inspection. It was unclear if the post was under recruitment or if the post was being withdrawn and reconfigured into a new post. This gap in support had an impact on the person in charge's capacity to fully fulfil the monitoring duties associated with their role as a person in charge of this designated centre.

An annual review of the quality and safety in the centre for 2022 was conducted by

a representative of the provider in January 2023. The annual review completed by a member of the quality team external to the campus provided a thorough and accurate overview of the centre, including consultation with residents and evidence of their lived experience. While the provider did have monitoring systems in place, including six-month unannounced visits and audits of practice, it was highlighted in the review that the system to monitor and follow through with actions had not proved to be effective in ensuring improved standards and compliance.

On review of the roster, the staffing levels were overall in line with the centre's statement of purpose, but a review was required to ensure that the levels fully met residents' needs and facilitated residents' meaningful activities outside of the designated centre and outside of the campus. For instance, not every shift had a driver rostered, and therefore, there was a reliance on the use of taxis as the centre was not serviced well by public transport. It was also not evident that staffing levels were in line with residents' social needs.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre for its registration, including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. While the statement of purpose contained all the required criteria, the inspector found some areas of service provision were not being operated in line with the statement of purpose. This included centre governance arrangements and the delivery of positive behavioural supports, which is discussed in the next part of the report under Quality and Safety.

Regulation 14: Persons in charge

The person in charge was responsible for the running of this centre and held a full-time position as the person in charge and CNM2. The person in charge had been in post since October 2022. This individual held the necessary skills and qualifications to fulfil the role. Residents were familiar with the person in charge.

They had a very good knowledge and understanding of the needs of residents, and they demonstrated commitment to supporting residents and the staff team. The person in charge was on call every second weekend for the entire campus, and they welcomed the addition of two new night managers to the centre, which would alleviate some of their large managerial remit.

The person in charge was also on call for the campus during the inspection due to the annual leave of the CNM3 and had to take a number of calls, increasing their governance remit on the day. The newly appointed CNM2 night manager was on site as part of their induction and offered to take over this responsibility to afford the person in charge time to facilitate the inspection

Due to the size and operations of the centre, the person in charge was to be supported by two CNM1s, one based in each of the two nurse-led houses. One of these posts was vacant for a long period of time. Therefore, the person in charge

was not fully supported to have the capacity to ensure effective oversight and operational management of this centre. This is addressed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 15: Staffing

The skill mix of the centre included nurses, social care workers and healthcare assistants. The centre had a whole-time equivalence (WTE) of 28.14 staff. Overall, the centre's staffing levels were in line with the statement of purpose. At the time of the inspection, there were two vacancies and other short-term leave. The inspector was informed that a successful open day was held the previous week, whereby these positions would be filled.

Two staff members were on duty each day in the houses and one staff member at night time. From observations made during the inspection and actions arising from the annual review and audits regarding the need to increase meaningful activities for residents, it needed to be evident these could be sustained with the current staffing levels.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider did have monitoring systems in place, but several areas for improvement which had been actioned during previous inspections; the provider's own annual review and audits were outstanding and found to have regulatory non-compliance on the current inspection. While the provider had made improvements to the oversight arrangements of the centre, these were still in their infancy. The inspector was also informed that the provider had funded another half-time CNM3 position in the centre.

However, at the time of the inspection, there were several outstanding quality improvement actions as listed in the centre's annual review and quality improvement plan.

For example, in January 2020, the inspector noted that while the number of staff present was sufficient to support residents within their homes, it was sometimes difficult to organise frequent community-based activities with the level of staff present. This led to some residents experiencing very low levels of community activation. This was a repeated finding for the annual review for 2022 and as identified in this inspection.

The inspector reviewed the six-month unannounced audit completed in the centre from July 2023. The provider had an assessment tool for use in these visits to assess how the centre was performing. The inspector found that sections were not completed in full, and it was unclear what progress had been made in actions arising from the previous six-month unannounced audit. For example, some actions listed as being late for completion on the quality improvement plan were not referred to in the six-month audit. Progress in relation to the findings of the annual review was not detailed, and limited information was provided regarding consultation with residents and staff.

Furthermore, the failure of the provider to provide adequate management systems to support the capacity of the person in charge also had a direct impact on the overall effectiveness of the monitoring of the quality and safety of care in this centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose contained all required information, as per Schedule 1.

Judgment: Compliant

Quality and safety

The inspector found that improvement was required to ensure the centre was being operated in line with the centre's statement of purpose. The provider had not ensured that this centre was adequately resourced to meet the objectives as set out within the statement of purpose. Improvements were required to aspects of the governance and management to ensure the effective oversight of the quality and safety of care.

As per the centre's statement of purpose, all houses within the designated centre can accommodate residents with behaviours of concern. The services provided to support these residents include a clinical nurse specialist in behaviours of concern and access to psychology services. The inspector found that some residents had positive behavioural support plans outlining reactive and proactive strategies to guide staff responses in managing behaviours of concern; however, these were not in place for all residents. Furthermore, there were also delays in accessing these services due to resource issues.

As part of the personal planning process, goals were identified for residents during person-centred planning meetings, which residents attended. There was some

evidence that residents were being supported to achieve their goals, which included attending community-based activities; however, it was also found that for some residents, access to meaningful activities off campus was limited. For example, a 'Quality of Life' audit carried out in July 2023 found minimal access to community activities for one resident and concerns that the requirement for 2:1 staffing was not also available and, therefore, was restrictive in nature for the resident. During a discussion with management, it was mentioned to the inspector that a recording error may have occurred in the activities that had been completed in the month. However, evidence was not available that this had been reviewed for accuracy. The inspector viewed documentation relating to staff planning for the resident to attend swimming in conjunction with day service staff after the results of the audit; however, it was unclear and unknown during the inspection if this took place.

The inspector reviewed a sample of the residents' assessments and personal plans. The inspector found improvements had been made to the quality and layout of residents' plans since the introduction of a new personal planning tool. Residents' positive behaviour support plans were contained within residents' overall individualised personal plans, which are intended to set out the health, personal and social needs of residents. In keeping with the requirements of the regulations, these positive behavioural support plans must be informed by a clear assessment process, subject to an annual multidisciplinary review, and also be available for residents in an accessible format.

The inspector found the person in charge had taken responsive steps within their capacity to reduce the occurrence of safeguarding incidents due to behaviours of concern. This included reviewing and amending rostering hours to ensure additional staffing supports were in place during pre-identified periods when incidents were more likely to occur. Also, due to compatibility issues, with residents' permission, some residents changed bedrooms due to identified risks at night time. Two residents within this bungalow were also recently reviewed by the behavioural CNS. Nonetheless, the inspector found there were delays in reviewing all positive behaviour support plans as outlined in Regulation 7, Positive behaviour support.

Several environmental restrictions were implemented within the centre, which had been notified to the Chief Inspector. These included exit doors being locked across the three buildings, locking of two kitchen doors, lap belts, modified clothing, bed rails, and sensor mats. Additionally, new restrictions had been identified and notified in light of recent restrictive practice thematic inspections, webinars and guidance from the Health Information and Quality Authority. The provider recognised these restrictions impacted the right to freedom of movement and access. These included staff-only areas in each of the bungalows and the locking of residents' finances in the office. The inspector was informed that safes were being purchased so residents could safely keep their money in their bedrooms.

The front door of each of the bungalows was opened via a swipe magnet card. The provider had commenced restriction reduction plans in relation to this restrictive practice, as while this restriction was in place to mitigate the risk for some residents, all residents were impacted equally. Larger magnets were available beside the front door in order for residents to open the door. These were, however, unsuccessful for

some residents to use.

Regulation 5: Individual assessment and personal plan

Personal plans provided guidance on the support to be provided to residents and had been recently reviewed. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs, including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans.

Residents' individual preference forms for where they would like to live and with whom had not fully been completed; this was an outstanding action on the centre's quality improvement plan from May 2021. Completed preference forms reviewed by the inspector did not have details contained within the attached action plan to track and record progress.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had a policy on the provision of behavioural support as required by the regulations, Policy on Supporting Person with Behaviours of Concern. The policy was originally devised in October 2005 and had undergone a number of updates, with the last review taking place in April 2021. However, from reviewing the references and bibliography section of the policy, the latest accessed references were listed as 2017. The inspector found the policy required a further review due to some outdated organisational information and to ensure that it was updated to reflect the latest developments and best practices.

In relation to the provision of positive behavioural support for residents and staff, the scope of the policy stated that support would be made available to residents within available supports, as opposed to being made available due to residents' assessed needs. The inspector found that due to resource issues and vacancies within psychology and behavioural disciplines, residents did not always have timely access to support. The inspector observed one resident engage in behaviours of concern during the inspection, including slapping of self and agitation, as well as making several requests to leave the bungalow. While staff were seen to comfort the resident, the resident had not been referred for positive behaviour support, and therefore, it was not clear how staff were to respond effectively to these behaviours within the current staffing arrangements.

The locked door restriction refers to the front door of each of the bungalows as it is opened via a swipe magnet card. The provider had commenced restriction reduction plans in relation to this restrictive practice, as while this restriction was in place to

mitigate the risk for some residents, all residents were impacted equally. Larger magnets were available beside the front door in order for residents to open the door. These were, however, unsuccessful for some residents to use. In one bungalow, the magnet is released, and the door is open from 8am to 8pm every day. The provider identified that this remained a restriction for some residents due to their physical disability and being unable to open doors without support from staff.

It was notified to the Chief Inspector that a restrictive review in February and June 2023 that the use of a sensor alarm was discussed. This would allow residents who could not manually operate the magnet system to gain egress by automatically opening doors. However, at the time of the inspection, the replacement of the locking system was still under review.

Judgment: Not compliant

Regulation 8: Protection

As mentioned, there had been incidents of a safeguarding nature in the centre. The provider had ensured effective systems were in place to guide and support staff on the timely identification, response, reporting and monitoring of any concerns relating to the safety and welfare of residents. Evidence showed that the actions outlined in current safeguarding plans had been implemented. There was also evidence of input from the provider's designated officer.

The inspector identified there has been a reduction in the number of safeguarding incidents since measures were implemented; however, ongoing compatibility issues remained, which have been actioned under Regulation 5 Individual Assessment and Personal Plans.

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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glen 2 OSV-0001439

Inspection ID: MON-0034795

Date of inspection: 27/10/2023

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
The Service Manager in conjunction with the PIC and PPIM will review the staffing and skill mix in the Centre taking into consideration day service support available to the Centre to ensure the skill mix meets the needs of the residents.

The PIC will ensure there are accurate daily records of quality-of-life activities maintained for each person and these are audited monthly and actioned appropriately.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Service Manager will ensure a nominated provider audit will be completed for the Centre by 31st December 2023

The PIC will ensure the compliance log for the Centre is maintained up to date.
The Service Manager PPIM and PIC will have monthly governance and oversight meetings for the Centre which will include review of the compliance log.

The statement of Purpose has been reviewed and is updated.

The Governance Structures in St Louise's have been enhanced to include 2 WTE night managers (CNM2's) and a .5 WTE CNM3, the 3 posts have been filled and are in place. The CNM1 vacancy has been converted to a staff nurse position.</td></tr>
<tr><td>Regulation 5: Individual assessment and personal plan</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</td></tr>
</table>

The Provider has revised the compliance plan for 2021 in relation to completion of Individual Preference and Need Assessment (IPNA)

A new care plan template was devised incorporating a comprehensive assessment of need (AON). This is now in place for all residents.

An Individual Preferences Needs Assessment (IPNA) will be completed where there is an identified changing need in relation to a person's residential accommodation and or it is the persons will and preference to explore alternate living accommodation.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider will ensure the policy on Supporting Person with Behaviours of Concern is reviewed - areas highlighted by the inspector in this report will be considered in this review.

The PIC will ensure referrals are made to the MDT including CNS in PBS as appropriate for residents identified needs as required.

The PIC will ensure all restrictive practices in the Centre are reviewed in conjunction with the MDT and that all avenues are explored to eliminate restrictions or where this is not possible to ensure any restriction in place is the least restrictive for the shortest time possible.

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.	Substantially Compliant	Yellow	31/01/2024
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.	Not Compliant	Orange	31/01/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	31/12/2023

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2024
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	31/03/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging	Not Compliant	Orange	08/12/2023

	behaviour.			