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:	Idrone Lodge
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Carlow
Type of inspection:	Unannounced
Date of inspection:	20 October 2021
Centre ID:	OSV-0005515
Fieldwork ID:	MON-0029134

About the designated centre

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

Idrone Lodge is a residential home located in Co.Carlow. The service has the capacity to provide supports to four adults over the age of eighteen with an intellectual disability. The service operated on a full-time basis with no closures ensuring residents are supported by staff on a 24 hour 7 day a week basis. Residents were facilitated and supported to participate in range of meaningful activities within the home and in the local and wider community. The property presents as a large bungalow on the outskirts of a large town. Each resident has a private bedroom, with a shared living area space. A variety of activity rooms are available such as an art room and sensory room. The centre also incorporated a spacious kitchen dining area and a garden area

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 - 2015 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 20 October 2021	09:30hrs to 17:30hrs	Leslie Alcock	Lead

What residents told us and what inspectors observed

This was an unannounced inspection completed to assess the centre's ongoing compliance with regulations and standards. The inspection took place during the COVID-19 pandemic and therefore appropriate infection control measures were taken by the inspector and staff to ensure adherence to COVID-19 guidance for residential care facilities. This included the wearing of personal protective equipment (PPE) and maintaining a two metre distance at all times during the inspection day.

The designated centre comprises a large bungalow in a residential area of a small town. It was comfortable and, homely with a large, well maintained garden. The residents had their own bedrooms which were personalised to suit their preferences and had space to store their personal belongings. The house had large communal areas and activity rooms such as an arts and crafts room and a sensory room, where the inspectors observed the residents utilise throughout the day.

The inspector spoke with the residents to determine their views of the service, observed where they lived, observed care practices, spoke with staff and reviewed the residents' documentation. This information was used to gain a sense of what it was like to live in the centre. On arrival, the inspector was greeted by staff and one resident. Another resident was observed in the sitting room engaging with sensory equipment, as two others were having their breakfast in the kitchen. After their breakfast, the inspector observed one resident return to their room to rest while the other resident brought the inspector around to show them different parts of the centre.

The inspector had the opportunity to meet and spend time with all four residents on the day of the inspection. Residents moved freely throughout the house and appeared very comfortable in their environment and in the company of staff. In general, the inspector found that the residents were supported throughout the day by the staff. Staff demonstrated that they were aware of residents individual communication needs and were observed to communicate with the residents in an effective and respectful manner. The inspector also observed the residents approach staff when they required support.

The residents enjoyed personalised activation schedules. Activities were based on the individual interests of the residents. On the day of the inspection, the residents went for their weekly outing to pick up supplies for the centre and a coffee, later they went for a walk by the river. The residents were also supported to utilise the activity rooms in the centre. In addition to this, the inspector observed a staff member support a resident research gardening ideas for the centre's garden.

The inspector observed respectful, warm and meaningful interactions between staff and the residents during the day. Staff spoken with on the day of inspection spoke of the residents in a professional manner and were keenly aware of their needs. Staff were observed adhering to guidelines and recommendations within

individualised personal plans to support the residents to achieve a good quality of life.

In summary, based on what the residents and staff communicated with the inspector and what was observed, it was evident that the residents received good quality care and support. The next two sections of this report outline the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. Some improvements were required to ensure that the service provided was safe at all times and to promote higher levels of compliance with the regulations. This was observed in areas such as; fire safety, notifications of incidents and protection against infection.

Capacity and capability

Overall, the inspector found that the registered provider demonstrated the capacity and capability to support the residents in the designated centre. The centre had a clearly defined management structure in place consisting of a person in charge, who worked on a full-time basis in the organisation. The person in charge was found to be competent, with appropriate qualifications and experience to manage the designated centre. This individual also demonstrated good knowledge of the residents and their support needs. While the person in charge had responsibility for three centres, they were supported by the staff team and the community services manager. Regular provider audits had taken place such as the annual review and the six monthly unannounced audits. Actions plans were developed as a result of the audits to address areas in need of improvement.

Overall, the staff team were found to have the skills, qualifications and experience to meet the assessed needs of the residents. There were some staff vacancies and where cover was required, it was found that a small group of regular agency staff were used to cover absences. This ensured consistency of care for the residents. All mandatory training was in place with a small number of staff requiring updated refresher training. The provider had scheduled dates in place for the completion of same.

While there were management systems in place to monitor the quality and safety of the care and support delivered to the residents, this required further review to ensure more effective and consistent oversight of the centre when the person in charge was absent for an extended period. The inspector found that staff supervision, team meetings and notifications of incidents did not occur in line with policy while the person in charge was unexpectedly absent for an extended periods. As a result of these absences, the person in charge developed a work-plan to ensure their responsibilities were delegated appropriately should there be another

unplanned absence.

Regulation 14: Persons in charge

There was a full time person in charge who was found to be suitably qualified, experienced and competent to ensure the effective operational management and administration of the centre. The person in charge demonstrated regard for the residents and in depth knowledge of the residents and their assessed needs. The person in charge had responsibility for three centres and for the most part divided their time evenly.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual staff rota in place and it was reflective of the staff on duty on the day of the inspection. There was appropriate skill mix and numbers of staff to meet the assessed needs of residents. The provider ensured continuity of care through the use of an established staff team and a small group of regular agency staff where required.

The inspector spoke with staff over the course of the inspection and found the staff team to be caring, professional and knowledgeable about the residents in their care. The staff were seen to interact with the residents in a warm, respectful and dignified manner. Nursing care was also available when required.

A sample of personnel files were reviewed and they contained all the required documentation as per Schedule 2 of the regulation.

Judgment: Compliant

Regulation 16: Training and staff development

The staff were supported and facilitated to access appropriate training including refresher training that was in line with the residents' needs. A training department was in place to ensure staff were notified of any upcoming training or refresher training needed. The inspector viewed evidence of mandatory and centre specific training records. All mandatory training was in place with a small number of staff requiring updated refresher training. The provider had scheduled dates in place for the completion of same.

Supervision records known as quality conversations,were reviewed. Discussion with the person in charge highlighted that while one to one formal supervision had taken place for staff it wasn't taking place at intervals in line with the providers own policy which is once every quarter. The person in charge communicated that this was due to unforeseen extended absences and a change of centre management earlier this year. The person in charge also communicated that they have developed new guidelines to ensure supervision is conducted regularly in the event of another absence. It was communicated and observed that the person in charge had a regular presence in the centre and provided ongoing informal support to staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had appointed a full time, suitably qualified and experienced person in charge who had regular oversight. This individual was supported by a community services manager and the staff in the centre. There were clear lines of accountability and responsibilities and effective arrangements in place to ensure the safe and quality delivery of care to the residents.

The registered provider ensured there was a clearly defined governance structure within the centre which ensured that residents received a service which met their assessed needs. All provider level audits and reviews as required by the regulations had been completed and where actions were identified, plans were in place to address these to improve the overall quality and safety of care.

The person in charge ensured internal audits such as hygiene, food safety, medicine management, personal care planning and finance were taking place regularly. These audits were delegated among the staff team and were completed on a weekly, monthly or quarterly basis, as appropriate. It was observed that the person in charge ensured these audits were conducted and reviewed during quality conversations with staff however, as mentioned previously, formal quality conversations with staff had not taken place at intervals in line with the provider's own policy. In addition to this, the inspector found that while regular management meetings took place, team meetings had not taken place when the person in charge was absent. Following these recent unforeseen extended absences, the person in charge developed a work-plan template to guide management and the team to ensure audits are conducted and reviewed, incidents, safeguarding plans and restrictive practices are reviewed and actions taken where appropriate, and quality conversations and team meetings take place, in the event of another absence.

The inspector noted that there had been a gap in the governance arrangements for this centre. This was acknowledged by the inspector as having occurred as an outcome of unforeseen absence however, the provider had not ensured there was effective oversight during this time. As a result staff supervisions, staff meetings and some in-centre audits and completion of previously identified actions had not been

carried out. In addition audits that were being completed were not adequately identifying issues that were present as found by the inspector on the day.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose and function is a governance document that outlines the service to be provided in the designated centre. The statement of purpose was available in the centre. A few minor amendments were required in relation to the purpose of two rooms in the centre. These amendments were made on the day of the inspection to ensure it contained the information the required by the regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of restrictive practice records and the designated centre adverse events register took place. This review indicated that quarterly notifications in relation to a minor injury in quarter one was not submitted to the Chief Inspector as required. It was communicated that this was as result of the absence of the person in charge.

Judgment: Not compliant

Quality and safety

The inspector reviewed a number of key areas to determine if the care and support provided was safe and effective to the residents at all times. This included meeting residents and staff, observing care and support and conducting a review of risk documentation, fire safety documentation, residents personal care plans and cleaning schedules.

Overall, the inspector found that the centre provided a comfortable home and person centred care to the residents. The management systems in place ensured the service, for the most part, provided appropriate care and support to the residents. However, there were some improvements required in relation to protection against infection, the premises and fire safety.

The residents' personal care plans had an up-to-date assessment of need which appropriately identified residents health, personal and social care needs. The

assessments informed the residents personal support plans which were up-to-date and suitably guided the staff team. The residents had an annual review called a 'visioning' meeting where the residents interests, likes, skills, talents, and their health and well-being were reviewed.

It was evidenced that the management team had regular oversight of the service provided and appropriate risk management procedures were in place. The inspector found that there were systems in place to assess and mitigate risks. There was a centre risk register in place and individualised risk assessments. Risks relating to the current COVID-19 pandemic had also been carefully considered, with appropriate control measures in place. However, some issues were identified on the day of inspection which required further review to ensure all aspects of the centre are cleaned and this is documented accurately.

In addition to this, fire safety measures required further review. While the centre had suitable fire safety equipment in place, including emergency lighting, detection systems and fire extinguishers which were serviced as required. A number of containment measures in place did not ensure adequate containment in the event of a fire. The registered provider promptly addressed this issue on the day of the inspection. The provider had identified the issue prior to the inspection and addressed it with the team, however the issue still required immediate attention on the day of the inspection suggesting the system to ensure fire containment measures are working effectively requires review.

Staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff spoken with had a good knowledge of safeguarding procedures and told the inspector what they would do in the event a safeguarding concern arose. Residents presented as safe and well cared for, based on the inspector's observations.

Regulation 17: Premises

The designated centre comprised of a large bungalow in a residential area of a small town. It was designed and laid out to meet the needs of residents. The centre presented as a warm and homely environment decorated in accordance with the residents' personal needs and interests. The residents bedrooms were decorated in line with their preferences with pictures and photographs on the walls. Along with large communal areas such as the sitting room and kitchen, the centre also had a sensory room, an arts and crafts room, a beauty room and a room for visitors.

The designated centre had a large well maintained garden with vegetables and plants that the residents enjoy taking care of. For the most part, the provider had ensured the provision of the requirements set out in Schedule 6 including adequate storage, and adequate social, recreational spaces as well as kitchen, bathroom and dining facilities. However, there were areas in the centre in need of maintenance in relation to the flooring in two bathrooms and the wall in another bathroom. The inspector reviewed maintenance records and these issues had not yet been

identified as in need of repair.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had detailed risk assessments and management plans in place which promoted safety of residents and were subject to regular review. There was an up to date risk register for the centre and individualised risk assessments in place which were also updated regularly to ensure potential seasonal risks were identified and assessed. There was an effective system in place for recording incidents and accidents. This system included an incident analysis that recorded the type of incident, the level of distress caused, actions taken, if further action was required and if the appropriate authority were notified.

Judgment: Compliant

Regulation 27: Protection against infection

The provider and person in charge had taken steps in relation to infection prevention and control in preparation for a possible outbreak of COVID-19. The person in charge ensured sufficient personal protective equipment was available at all times and staff had adequate access to hand sanitising gels and appropriate hand washing facilities. Risks associated with residents and staff contracting COVID-19 had been carefully considered and risk assessed with appropriate control measures in place. An up to date COVID-19 preparedness and service planning response plan was also in place. The provider also completed the HIQA Self-assessment Tool on preparedness planning and infection prevention and control assurance framework for registered providers.

There was a cleaning schedule in place that included deep cleaning of all aspects of the designated centre. The inspector found that there were gaps in the schedule the week of the inspection and the week prior to the inspection. The cleaning schedule outlined a particular day in a week certain that equipment should be cleaned and the records indicated that not all equipment was cleaned the week prior to the inspection. The same equipment was not included in the cleaning schedule two weeks prior to the inspection. It was unclear from the cleaning schedule when that equipment was last cleaned. A number of the activity rooms were also not included on the cleaning schedule. While they looked visibly clean on the day of the inspection, it was unknown when these rooms were last cleaned and by whom.

Judgment: Substantially compliant

Regulation 28: Fire precautions

In general, fire safety systems were in place that involved visual checks on the fire fighting equipment, containment measures, emergency lighting and evacuation routes. Staff training was up to date and there was personal evacuation plans in place for the residents. Evidence of regular evacuation drills which simulated both day and night time conditions were taking place. The documentation in place relating to evacuation drills outlined that the simulated fires took place in different locations in the centre, the length of time it took to evacuate, the evacuation route, the staffing levels and the overall effectiveness of the drill. The drill records also documented the learning derived from the drill which informed new evacuation procedures.

Fire detection and containment measures were in place in this centre including, fire doors, fire fighting equipment and an appropriate fire alarm system. The person in charge identified an issue with the fire doors in the kitchen and the hallway. These doors were due to be replaced but were repaired and deemed by the provider to be working effectively until the arrival of the new doors. An issue regarding the effectiveness of a number of other fire doors was noted on the day of inspection and this was promptly followed up with maintenance who fixed all the doors to ensure all appropriate containment measures were fully in place at the close of the inspection day. The person in charge had identified that the regular visual checks did not include ensuring the fire doors closed properly and addressed it with the staff at the September and October team meeting. Although the issue was identified it remained to be addressed until the day of the inspection which meant that the system in place to ensure fire doors work effectively requires review.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had comprehensive assessments of need completed and personal support plans in place which were subject to regular review. The individual social care needs of residents were being supported and encouraged and this was reflected in their personal support plans and during what were called 'annual visioning' meetings. The residents had an annual visioning meeting where their interests, skills, assets, and their health and well-being were reviewed. The review also considered conditions for success, personal relationships and what a meaningful day looks like for the resident. An action plan was development from the visioning meeting and ongoing assessment which identified resident focused goals, a person responsible and the timeline for completion of said goal. There was a key working system in place and evidence of the residents working towards achieving these goals through a monthly review process. It was evident from a review of these plans

that residents were receiving care which was person-centred and tailored to meet their assessed needs with regular input from multi-disciplinary professionals.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to ensure that residents were safeguarded from abuse in the centre. Staff had completed training in relation to safeguarding and protection and were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse. Staff were also familiar with who the designated officer for the centre was. There were no open safeguarding concerns and there was evidence that previous concerns were monitored, reviewed and dealt with appropriately. Residents had intimate care plans in place which detailed the level of self care ability and the level of support required. There was an up to date safeguarding policy in place that provided clear guidelines for staff should a concern arise.

Judgment: Compliant

Regulation 9: Residents' rights

The provider ensured residents were consulted and encouraged to participate in how the centre was run. For instance; house meetings took place regularly and items discussed included; actions from the previous week, activities for the upcoming week, satisfaction with the menu and further planning, and the complaints procedure. There was an easy to read version of the meeting minutes which included pictures of the food for the menu planning aspects.

The inspector found that personal care practices respected resident's privacy and dignity. The staff were seen to interact with residents in a respectful and dignified manner. The inspector observed staff offer residents the opportunity to exercise choice and control in their daily lives. Choice and control was also explored in the resident's 'annual visioning' meetings and reviews.

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 - 2015 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 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Idrone Lodge OSV-0005515

Inspection ID: MON-0029134

Date of inspection: 20/10/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Refresher training for staff members in Idrone Lodge are booked and evident on the training report. Outstanding medication assessments will be completed by the staff nurse in Idrone Lodge with the relevant staff members by latest 20/12/2021. The next available date for staff to attend refresher training in medication management is scheduled for 16/12/2021. Quality Conversations for the staff team in Idrone Lodge are scheduled in line with SPC policy. In the absence of the PIC the PPIM ensures completion of any upcoming Quality Conversations.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure adequate governance & management of all designated centres, SPC has developed a Workplan for the absence of PIC. This workplan has been agreed at the Quality Assurance Meeting on 01/07/2021 and rolled out across the service. In the absence of a PIC the PPIM will take lead in assigning delegated duties as per this workplan and ensure completion of Quality Conversations, Team meetings and follow up on any other relevant actions to ensure safe and quality service.	

Team meetings have a standard agenda to guide the staff team in discussing areas, such as e.g. risk management, incidents, safeguarding, training needs, etc.

The PIC and PPIM will also discuss the delegation and completion of audits within the staff team at the next team meeting in December and highlight the importance of following through on any identified actions.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC has completed quarterly returns notification in line with Regulations since the inspection took place.

The Quality Manager has sent a reminder and support email to all PICs and PPIMs on the 26/11/2021 regarding the requirements within Regulation 31.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Cleaning of both bathrooms has been completed since the inspection took place to remove built up limescale on flooring and the wall. A deep clean is scheduled to be completed by maintenance department with appropriate limescale remover the week commencing on the 06/12/2021.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Cleaning schedules for Idrone Lodge have been reviewed and updated to include the activity rooms has been updated and ensure all equipment for the ladies supported is cleaned.

The adherence and completion of cleaning schedules and checklists has been added to the agenda for the team meeting in December 2021.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Necessary interim repair works and adjustments of fire doors had been completed on the day of the inspection in Idrone Lodge to ensure full fire safety in Idrone Lodge. H & S department is awaiting quotation for replacement of two fire doors, one for the kitchen and one for the hallway. The builder advised that the ordered doors have to be produced specifically due to the size of the doors.

The PIC has addressed the importance of fire checks with the staff team since the inspection took place, especially to ensure visual checks on closure of fire doors to be completed. This issue will also be discussed at the December team meeting in Idrone Lodge.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	20/12/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/12/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	11/12/2021
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	15/12/2021

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	11/12/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	28/02/2022
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring	Not Compliant	Orange	26/11/2021

	in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).			