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:	Tús Álainn
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	17 October 2019
Centre ID:	OSV-0005731
Fieldwork ID:	MON-0024014

About the designated centre

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

Tús Álainn is a designated centre operated by Saint Patrick's Centre, provider. The designated centre is a detached bungalow located in the suburbs of Kilkenny town and ideally located for residents to engage with local amenities to promote and support their social inclusion and integration with the local community. The designated centre has a capacity for three adult residents, and the provider has decided that the centre is for female gender only. Tús Álainn designated centre provides full-time residential services for people with intellectual disabilities and complex health care needs. This designated centre commenced operation in May 2018 as part of Saint Patrick's Centre overall de-congregation plan.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
17 October 2019	09:00hrs to 16:30hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

The inspector met with three residents on arrival to the centre. One resident had just finished their breakfast and was relaxing at the dining room table. Another resident was relaxing in bed; staff informed the inspector that they enjoy a lie-in a couple of mornings during the week. The third resident was just commencing their morning routine upon the inspector's arrival. Interactions observed between residents and staff at this time were positive in nature. Staff actively engaged with residents when going about the morning routine.

The centre was a hive of activity with residents coming and going throughout the day partaking in a range of activities such as attending their day service and going out to the local coffee shop. Residents chose not to interact with the inspector but to continue with their plan for the day. This choice was respected.

Residents appeared very comfortable in the company of staff, smiling and maintaining eye contact with them throughout their interactions. Staff were knowledgeable to the needs of the residents. All information relating to the individual needs of the residents was presented in a respectful dignified manner.

Capacity and capability

Tús Álainn presented as a centre where the registered provider demonstrated high level of compliance. The capacity and capability of the provider ensured residents were supported to enjoy an active life, participating in a range of meaningful activities within the local community. Whilst a clear governance structure and efficient staff team had been appointed to the centre, improvements were required in a number of areas such as staffing training and supervision to ensure adherence to regulations, to ensure a safe, effective service was afforded to residents. A number of areas of non-compliance identified within previous inspections continued to require actions. For example, staffing levels and fire safety continue to require review.

The registered provider had appointed a suitably qualified and experienced person in charge to the centre. This individual possessed the regulatory required skills knowledge and experience to fulfil their role. They reported directly to the person participating in management allocated to the centre. There was clear evidence of communication within this governance structure. Whilst a board of management was in place within the organisation and actively engaging in the operation of the centre and organisation, notification had been received by the authority of their withdrawal

by December 2019.

The registered provider had not ensured the implementation of organisational level monitoring systems. Whilst an annual review of service provision by a delegated person had been completed systems were not in place for the implementation of six monthly unannounced visits to the centre. The annual review was comprehensive and incorporated the views of the service users where possible. Parts of non-compliance's had been recognised through these monitoring systems. At centre level the person in charge ensured monitoring systems were utilised to drive service improvements and to be alerted to concerns/issues in a timely manner. These systems included such areas as finance audits, fire checks and health and safety audits. These systems incorporated assistance from all members of the staff team.

The registered provider allocated a number, skill mix and qualifications of staff which they deemed appropriate to the number and assessed needs of the residents. Evidence of ongoing review of staffing levels required review to ensure that staffing levels at both day and night were appropriate to meet the assessed needs of all residents currently residing in the centre. The person in charge had ensured systems were in place for the staff team to communicate any concerns or issues which arise. The person in charge was allocated direct support hours and utilised these to ensure the day to day operations were effective and a team approach was paramount to ensure a safe effective service was afforded. The person in charge had however, not ensured that supervision of staff had been completed in accordance with local policy. This was acknowledged by the person in charge as an issue requiring action.

The registered provider had acknowledged training they deemed as obligatory to ensure the residents were afforded supports in a safe and effective manner. Residents within the centre had been assessed as having individual and specific needs such as manual handing support needs. The person in charge had not ensured measures had been implemented to ensure staff were supported and facilitated to attend relevant training including refresher training. Some training needs had been booked for the coming weeks, with the obligatory training needs of the centre currently under review by the governance team.

The registered provider had ensured the development of an effective complaints procedure which was disseminated to residents and staff through a number of avenues including organisational policy and training. Through the organisational policy residents and staff were provided with guidance on procedures to adhere to should a complaint arise. It was evident through review of the complaints log that residents are supported and facilitated to submit a complaint should they wish. The process in place ensured that all complaints were addressed in a timely manner with the satisfaction of the complainant achieved. Details of the complaints officer visible throughout the centre required updating to ensure this information reflected the correct personnel.

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider allocated a number, skill mix and qualifications of staff which they deemed appropriate to the number and assessed needs of the residents. Evidence of ongoing review of staffing levels required review to ensure that staffing levels at both day and night were appropriate to meet the assessed needs of all residents currently residing in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had not ensured that supervision of staff had been completed in accordance with local policy.

The person in charge had not ensured measures had been implemented to ensure staff were supported and facilitated to attend relevant training including refresher training.

Judgment: Not compliant

Regulation 23: Governance and management

A clear governance structure had been appointed to this centre. Whilst a board of management was in place within the organisation
and actively engaging in the operation of the centre and organisation, notification had been received by the authority of their withdrawal by December 2019.

Whilst an annual review of service provision by a delegated person had been completed systems were not in place for the implementation of six monthly unannounced visits to the centre. At centre level the person in charge ensured monitoring systems were utilised to drive service improvements and to be alerted to concerns/issues in a timely manner.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was available within the centre. Improvements were required to ensure that all required information within this document was up to date and reflected the service currently provided within the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all incidents required under the regulations to be notified were done so within the set time frame,.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had ensured the development of an effective complaints procedure which was disseminated to residents and staff through a number of avenues including organisational policy and training. However, details of the complaints officer visible throughout the centre required updating to ensure this information reflected the correct personnel.

Judgment: Substantially compliant

Quality and safety

The inspector reviewed the quality and safety of the service provided to the residents currently residing within Tús Álainn and found that residents were encouraged and facilitated to participate in a range of activities. Residents were supported to participate in community activation and participation in social roles. Residents were consulted in the day to day operations with the centre being operated in a manner that was respectful to the rights of all residents currently being afforded a service within the centre.

The registered provider had ensured that each resident was assisted and supported to communicate in accordance with the resident's unique needs and wishes. This was clearly visible throughout the day of the inspection. All interactions were positive in nature with staff clearly knowledgeable to the communication needs of the residents. The communication needs of each resident were set out clearly within the individualised personal plan.

The registered provider had ensured that each resident was afforded with access to facilities for recreation in accordance with their choice of activities. Choice of engagement in activities was respected. All participation in activities was recorded through the use of individual computer tablets. Photographs showed recent visits to an aquarium, birthday parties, social outings and visits to the local pub. Residents attended a local day service on days of their choice. These activities were facilitated by staff with a written record also maintained.

The person in charge had ensured the development and ongoing review of comprehensive individualised personal plans for each resident. The format to ensure information available was clear, concise and up to date was recently introduced to the centre and the completion of this was in progress. Needs assessments was completed annually ensuring all documented supports were reflective of the residents assessed needs. This incorporated multi-disciplinary input for relevant members of the individuals support team such as the physiotherapist or speech and occupational therapy. A number of support needs were addressed and regularly reviewed through monthly key worker meetings. However, visioning meetings were not occurring yearly to ensure the participation in goals was progressing and reviewed.

An organisational policy with regard to safeguarding vulnerable adults from abuse was in place which guided staff on procedures to keep residents safe. In conjunction to this, staff were facilitated to attend training in the area of safeguarding. Staff possessed a clear understanding to the needs of service users to promote this safety and to afford affection. Guidance was afforded in the area of personal and intimate care in a dignified and respectful manner. Staff completed twice daily checks of each individual's finances. Whilst completing a check of these systems the inspector identified an error in recording of one residents finances which had occurred three days previous. However, this error had not been identified by staff completing checks and the error remained in place. This was corrected by person in charge immediately.

The registered provider had ensured a risk management policy was in place incorporating the regulatory required information. An environmental risk register was in place which incorporated a plethora of identified risks including fire, lone workers and slips trips and falls. These risk assessments incorporated existing controls in place to reduce the likelihood and impact of the risk. However, some identified risk required further review to ensure that current control measures in place were effective and correct. For example, no lone worker risk assessment had been completed prior to the inspection and also at night support was afforded by a staff in a neighbouring centre, this was not reflected in a number of risk assessments such as fire evacuation and manual handling. This process was

also incorporated in to individualised personal risk assessments. Whilst staff spoke of the effectiveness of this arrangement a standard operating procedure in place did not clearly identify the place staff was to be called from.

Whilst the registered provider had ensured effective fire safety measures were in place such as containment measures and fire
fighting equipment, improvements were required to ensure that all staff
and residents were familiar with the correct evacuation procedures for a range of scenarios. Evacuation procedures in the centre were clear however and it was not demonstrated that staff could evacuate all residents living in the centre in a timely way. Whilst a ski-pad had been sourced to support one resident to safely evacuate the property in an emergency, this had not been trialled incorporating evacuation procedures set out for all scenarios such as lone workers.

Regulation 10: Communication

The registered provider had ensured that each residents was assisted and supported to communicate in accordance with the residents unique needs and wishes.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider had ensured that each resident was afforded with access to facilities for recreation in accordance with their choice of activities. Choice of engagement in activities was respected.

Judgment: Compliant

Regulation 17: Premises

The registered provider had ensured the premises were designed and laid out to meet the assessed needs of the residents. The centre was clean and tastefully decorated with photographs of the residents dispersed throughout.

Each resident had a private bedroom which they decorated in accordance with their

personal taste and interests with the support of family members and staff.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had ensured adequate risk management procedures were in place for the identification and assessment of risk in the centre. Some improvement was required to ensure that effective control measures were in place for all identified risks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Whilst the registered provider had ensured effective fire safety measures were in place such as containment measures and fire
fighting equipment, improvements were required to ensure that all staff
and residents were familiar with the correct evacuation procedures for a range of scenarios.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured the development and ongoing review of comprehensive individualised personal plans for each resident. This incorporated multi-disciplinary input for relevant members of the individuals support
team ensuring all documented supports were reflective of the residents assessed needs.

However, visioning meetings were not occurring yearly to ensure the participation in goals was progressing and reviewed.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider ensured residents were afforded with the best possible health having regard for their personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff were provided with up to date knowledge and guidance to support residents to manage their behaviours.

Where a restrictive practice was utilised this was done so in accordance with local and national policy.

Judgment: Compliant

Regulation 8: Protection

Improvements were required to ensure that systems in place to protect residents from all forms of abuse including financial were implemented in a consistent manner.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had ensured the centre was operated in a manner which was respectful to the residents. Consultation with residents was completed where possible.

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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Tús Álainn OSV-0005731

Inspection ID: MON-0024014

Date of inspection: 17/10/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staff rosters are under ongoing review to ensure appropriate support for the people living in Tus Alainn. Night staffing needs were reviewed across the service in St. Patrick's Centre (Kilkenny) to identify supports required in each designated centre and also reflect the current financial situation. Tus Alainn is provided with on call support from another house within 7 minutes driving distance. One person supported in Tus Alainn is availing of 2:1 support when retiring to bed and during a fire evacuation. A risk assessment and Standard Operating Procedure are in place to guide the staff team regarding the on call support.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All employees are supported to attend mandatory and mandated training. It is also the responsibility of employees to propose training that would enhance and support their role within St. Patrick's Centre (Kilkenny). A centre specific training profile, individual employee training profiles and a training schedule are distributed monthly to the PIC and CSM of the centre by the Training Department. Employee training is on the agenda of the monthly team meetings and also discussed individually through Quality Conversations. Training Update for Tus Alainn: • All employees have completed Manual & Patient Handling Training. 3 staff members	

are currently awaiting their refresher training. Two staff are booked to complete their refresher training on the 20/11. One staff is awaiting training dates in January 2020 to complete refresher training.
• All employees have completed Children First Training.
• All employees have completed Fire Training 1. One staff member is due to complete Fire Training 2. The PIC is currently awaiting a date for Fire Training 2.
• One staff member is due the refresher training Safeguarding Vulnerable Adults and is booked for completion on the 05/12/19.

SPC has a Quality Conversations policy in place. The policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for employees. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

The PIC has scheduled all outstanding Quality Conversations with the staff team until the end of 2019.

On the 07/11/19 a working group met in SPC to discuss capacity building around Quality Conversations and Coaching as a leadership style. A Quality Training Session is scheduled for the 06/02/2019 for all PIC's and Team Leaders to attend.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Governance:
SPC BOM intends withdrawing from the future governance of service provision (to include Tus Alainn) and therefore, in addition to submission by SPC, of NF35's to the regulator, SPC BOM has issued the HSE with formal written three (3) month's-notice, of its termination of the Agreement between it and the HSE, to expire on December 31st, 2019.
SPC would hope that if the HSE delivers on the identified outstanding issues, this Notice can be withdrawn. The BOM and SPC executive will work collaboratively with the HSE and all other stakeholders in the intervening period to ensure as seamless a transition as possible.

Quality Conversations:
The PIC has scheduled all outstanding Quality Conversations with staff members in Tus Alainn until the end of 2019 to ensure completion of same and follow up on outstanding training needs, delegated duties and actions arising.

The CSM and PIC have scheduled Quality Conversations and also attend the Team Leader and Cluster meetings.

Monthly PIC reports:
The Quality Department and Community Service Managers within St. Patrick's Centre (Kilkenny) have developed a monthly report template which supports and ensures the

management and governance between the CSM and PIC.
The monthly report template is completed by the PIC on the last Friday of the month and is basis for the Quality Conversations between CSM and PIC.

Provider audits:
Since the opening of Tus Alainn two annual provider audits were completed. A six monthly provider audit is scheduled for completion in December 2019. Completion date with the person identified to complete the audit was agreed for the 15/12/2019.

Identified actions from the audits are part of the PIC's action plans for completion and delegated duties to discuss at team meetings and Quality Conversations.

A schedule for completion of Provider audits has been developed by the Quality Department for 2019 and 2020. People responsible for completion were identified and timeframes set.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose was reviewed and updated and is now available in Tus Alainn in the House information and induction folders.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The updated complaints poster, reflecting the current PPIM and PIC is now displayed in Tus Alainn.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC and staff team are in the process of reviewing and updating all risk assessments and the risk register for Tus Alainn, using the new risk assessment and risk register template.

A risk assessment for people supported's finances and a risk assessment for one person supported's 'all in one' clothes were completed immediately after the inspection took place in Tus Alainn.

The review of risk assessments and the updating of the risk register in Tus Alainn will be completed by 30/12/2019.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Since the inspection took place on the 17/10/2019 the PIC and staff team have completed 1 day and 1 night time fire drill. Clarification was discussed with the staff team around documentation of the evacuation time. At the night time fire drill the ski pad was used for one person supported as evacuation aid and learning from the drill was documented.

The PIC and staff team are in the process of trialing different scenarios for fire evacuation to build capacity and confidence within the staff team. Drills are being scheduled and learning will be documented and discussed.

The PIC met with the fire officers on the 12/11/2019 to assess Tus Alainn and get familiar with the needs for the designated centre.

Risk assessment and SOP are in place for the fire evacuation in Tus Alainn to guide the staff team, especially regarding the responding staff from another designated centre within 7 minutes distance.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Personal Plan:
The Quality Department and Community Transition Coordinators have developed a new Personal Plan folder system for St. Patrick's Centre (Kilkenny). This personal plan is outcomes based and will ensure that person centred documentation evidences progress of goals and roles.

The new Personal Plan folder system was rolled out within St. Patrick's Centre (Kilkenny). Workshops for CSM's, PIC's and keyworkers were delivered on the 4th, 5th and 11th September to ensure transfer from the older filing system to the new Personal Plan folder.

Each person supported's documentation is now available in the new Personal Plan folder in Tus Alainn. Daily logs are available in a daily working file, matching the new file index in the Personal Plan folder.

The old personal plan template will be replaced in January 2020 by the new "My Profile". Workshops for keyworkers of all people supported will be rolled out end between 23rd and 30th January 2020 to ensure the development of "My Profile" and also build capacity for keyworkers around the SRV model.
Visioning/Roles/Goals:
A new visioning documentation toolkit (roles based planning toolkit) has been developed in St. Patrick's Centre (Kilkenny) and was rolled by the Community Inclusion Coordinator through workshops in July 2019, which the PIC and a staff member attended.

The staff team in Tus Alainn has started to transfer documentation relating to people's roles and goals on to the new progress/action plan templates. Progress of goals is also documented on each person's individual I-pad.

The PIC has scheduled reviews of visioning meetings for the people supported in Tus Alainn, using the new roles based planning toolkit. This will ensure that developed roles and goals will be reviewed and the introduction of new roles and goals can be agreed.

All review meetings will be completed by the 09/01/2019.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Immediately after the inspection took place the PIC spoke to all staff members on the 17/10/2019, especially the staff members involved in the identified error of financial checks.

One staff member in Tus Alainn is assigned as finance officer within her delegated duties, to ensure finances are checked and documented correctly.

The PIC discussed with the staff team at meetings on 20th, 21st and 25th October 2019 the finance pathway and will address the financial checks again at each staff members Quality Conversation.

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	30/12/2019
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	05/12/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/12/2019

Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/12/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	15/12/2019
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six	Not Compliant	Orange	15/12/2019

	months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/12/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	15/11/2019
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	11/11/2019
Regulation	The registered	Substantially	Yellow	11/11/2019

34(1)(d)	provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Compliant		
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	09/01/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	28/11/2019