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:	Kingsriver Community
Name of provider:	Kingsriver Community Holdings Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	09 March 2021
Centre ID:	OSV-0002410
Fieldwork ID:	MON-0031024

About the designated centre

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

Kingsriver Community consists of two buildings providing a home for up to six residents of mixed gender. The centre is open all year round and provides residential services to people with mild to moderate learning disabilities and mild physical disabilities. Medical and multidisciplinary support is provided as required. Day services are also provided on site Monday to Friday. One building is intended to serve as a supportive service to independent living. The centre is staffed by paid staff and volunteers. Any admissions to the centre are considered taking into account the needs of existing residents. Kingsriver Community does not facilitate emergency admissions. The provider's stated intention is to create a home for residents and there is an ethos of living together as a family group within a community. Each resident is actively encouraged to pursue their own interests and hobbies. Cultural events, various activities and education opportunities are provided for. Residents have access to a large garden area with an orchard, vegetable garden, polytunnel and glass house. Transport is provided to access activities away from the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Tuesday 9 March 2021	10:00hrs to 16:00hrs	Tanya Brady	Lead
Tuesday 9 March 2021	10:00hrs to 16:00hrs	Sarah Cronin	Support

What residents told us and what inspectors observed

This inspection took place during the COVID -19 pandemic and as such inspectors adhered to national guidance and best practice while completing the inspection.

This centre is home to six residents and all were present on the day of inspection. The residents were attending their day services for the duration of the day, however, inspectors met with one resident who had requested to speak to them. Inspectors also had an opportunity to briefly observe residents in the day service building as it was in the same building as office space used by inspectors. Over the course of the day, residents were seen to engage in a drama group, to sit and have lunch together in a canteen area and to mix socially in rooms set up for relaxation with a snooker table or places to sit. In addition, residents were observed as they moved around externally on site.

This centre is comprised of a large two-storey house on a 30 acre site next to a river. A second house which is currently part of the centre, but currently unoccupied, is close by. The provider has stated they are applying to remove the second house from the centre. The main house where all residents now live is an older house with a large modern extension. There are gardens with polytunnels and fruit trees in addition to areas set to grass, a covered patio is next to the kitchen door and a wide deck runs along the front of the main house. The provider's day service is also on site and residents can freely walk between their home and the day service building. The provider is to commence a substantive building upgrade to the house, including changing the layout internally over the next few months and as such maintenance and repairs that were noted to be required, are scheduled for completion as part of this plan. The provider is currently in the process of identifying suitable accommodation for residents to move to temporarily while the works on their home are carried out.

The residents' home has large shared communal spaces, a kitchen-dining room now has a second table to ensure that distancing can be maintained safely while still providing opportunities to share meals between staff and residents. A sitting room next to the kitchen has an area set aside for residents to complete exercises or physiotherapy programmes. There is a second smaller sitting room on the first floor. All residents have their own bedrooms which were personally decorated and one was en-suite. Residents each had a key to their bedrooms and could choose to lock them if they were not going to be at home. The person in charge checked with all residents prior to inspectors visiting their home. Bathrooms were noted not to be suitably clean and required attention. As mentioned above, there were areas that required maintenance, holes in the floor and walls and there was no door on the hot-press.

In this home, residents are supported by volunteers who live in the centre and paid staff. The provider describes this service as a life sharing model and on the day of inspection there was one volunteer living with residents in the community. Staff

were seen to accompany residents to their day service with one resident facilitated to another location run by the provider for their day service. Inspectors met the current person in charge, incoming person in charge and the team leader on the day of inspection and greeted the volunteer. The other staff member was not available to speak to inspectors as they were out supporting a resident. Staff spoken with were knowledgeable about residents' personal needs and their likes and dislikes, staff were seen to speak to residents with respect.

Inspectors noted on some documentation, however, that when residents were referred to in writing this was done with less respect than verbally and this was drawn to the provider's attention. The provider had policies in place as required by Schedule 5. However, these policies had not been updated as required by regulation and were therefore not guiding staff in current practice. In addition, not all policies had been updated to reflect COVID -19 protocols such as the visitors policy.

One resident had requested to meet with inspectors and was very interested in what the role of the inspectors involved and why they had visited their home. The resident also commented that they liked their home and liked the people they lived with. They had no complaints and remarked that they enjoyed coming over to the day service to take part in activities. Inspectors noted that residents had bicycles and tricycles stored in an open shed near the office space and residents used these to get around the large site. It was noted in resident meeting minutes that the numbers of bicycles had increased and how they were stored had been reviewed to ensure they could be independently accessed.

Inspectors noted that improvements were required in areas, such as risk management, infection prevention and control and safeguarding which will be detailed in the following two sections of the report.

Capacity and capability

The provider and person in charge had management structures in place to ensure that the service provided to residents was safe. However, these required improvement, in particular the auditing and oversight of systems to ensure that the service was consistent and appropriate to resident's needs.

The provider had expanded the local management team since the last inspection and the person in charge was now supported by a team leader in the centre. Lines of authority and accountability were in place and staff were clear about these and who they reported to. The application of oversight by the provider was, however, poor. The provider had completed a six-monthly unannounced visit in November 2020, however the previous one had been in October 2019. There was no annual review of the quality and safety of care available from the previous year. While an action plan had been devised from the last review it was unclear how progress

against these actions was monitored. Staff meetings were occurring and while there was evidence of informal communication this was not recorded in a way that any actions identified could be reviewed or audited. The person in charge was reviewing logs and records of practice, however, there were no audits consistently occurring.

The staff team in place was consistent and the skill-mix of staff was sufficient to meet resident needs at the time of this inspection. The inspectors were told that this would be reviewed as the restrictions currently in place due to the pandemic were lifted and residents would like to return to individual activities in the community. Inspectors reviewed staff personnel files and found that they did not contain all information as required by Schedule 2 of the regulations.

The provider was ensuring appropriate training and refresher training was provided for staff, however, one staff required refresher fire safety training since May 2020. Staff supervision was being implemented in line with the provider's policy. Where concerns had been raised regarding performance in supervision it was not clear to the inspector what systems had been put in place to support staff development and this was raised with the person in charge on the day. The provider however, outlined the actions plans that are in place and agreed with the staff member with goals monitored by the line manager.

Registration Regulation 5: Application for registration or renewal of registration

The application for renewal of registration of this centre was not received as required. This centre's current registration expires on 11/07/2021 and the application to renew registration was overdue. Some documents that required resubmission, such as the statement of purpose were discussed on the day of inspection and were sent to the Chief Inspector the following day.

Judgment: Not compliant

Regulation 15: Staffing

On the day of inspection there were appropriate levels of staffing and skill-mix of staff in place to support residents. The staff team in place was consistent and familiar with residents' needs. There were familiar staff available on a small relief panel to cover the roster if required. Inspectors viewed the current and planned roster and noted that it reflected the staffing in place.

Contingency arrangements were in place to ensure that, in the event of a shortfall of staff, due to the COVID-19 pandemic, additional staff (with garda vetting and

appropriate training) would be available.

A sample of Schedule 2 files was reviewed by inspectors and while they contained the majority of information required by the regulations inspectors found that some documents were missing from the sample reviewed. This included no CV or gaps in employment records for three staff, references for one staff member and no record of the position held by an individual in the centre for other staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided in mandatory and key areas for staff, however, one staff member was overdue fire safety refresher training since May 2020.

Supervision of staff was taking place in line with the provider's policy. The team leader supervised the staff team, they were in turn supervised by the person in charge. The person in charge also supervised the volunteers who may be present in the centre at any given time, and was supervised by the provider's chief executive officer. Where concerns had been raised regarding performance in supervision it was not apparent what systems had been put in place to support staff development and this was raised with the person in charge on the day. The provider however, outlined the actions plans that are in place and agreed with the staff member with goals monitored by the line manager.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was an up-to-date directory of residents available in the centre which contained all information as required.

Judgment: Compliant

Regulation 23: Governance and management

Systems were not in place to ensure the centre was monitored and audited as required by the regulations. There was no annual review of the quality and safety of care available for the previous year in the centre. The six-monthly auditing reports were also not occurring as required by the regulations. Action plans where they had been developed had no system for review that ensured improvements arising from

the auditing process were addressed in a reasonable time frame. For example, the most recent audit identified a number of issues regarding the upkeep of documentation of some resident's care plans.

Audits were not consistently being completed with only health and safety and fire audits available for review. There were no other systems in place to ensure that robust oversight of documentation and processes was occurring and limited systems in place to identify improvements that may be necessary.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had systems in place for the management of complaints in the centre and the policy had been reviewed in October 2020. Only one complaint had been received in 2021 and it had been dealt with in line with the provider's policy. No complaints had been recorded in 2020. The complaints officer told inspectors that they were currently engaged with staff to ensure they were identifying and recording complaints.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had policies in place as required by Schedule 5 of the regulations. These had not all been reviewed at intervals not exceeding three years, such as the positive behaviour support policy, finance policy, admissions policy and missing persons policy. In addition, a number of policies had not been updated to reflect COVID-19 protocols, such as the visitors policy.

As such, the policies in place to guide staff practice were not current and had not been adapted to reflect current best practice guidance.

Judgment: Not compliant

Quality and safety

Overall, while positive practices were observed in the centre, with residents observed to be supported in a person-centered manner, improvements were required in areas such as risk management, infection prevention and control and

safeguarding of residents.

The individual social care needs of residents were being supported and encouraged. From viewing a sample of files, the inspectors saw that the residents were being supported to maintain safe links with their families and friends. In addition, reviews of personal plans had been occurring with goals for individual residents in place. At the time of this inspection, access to the community was restricted for residents due to the current COVID-19 pandemic. However, residents were supported to go for walks, drives and cycles and to attend their day service.

All staff had received training in the safeguarding and protection of vulnerable adults. The provider had ensured safeguarding plans from 2018 and 2019 had been reviewed and closed where appropriate with learning from these evident. Where safeguarding concerns had since occurred there were interim safeguarding plans in place, ensuring residents were supported immediately following an incident but inspectors noted plans did not provide measures to protect residents in an ongoing manner. Management of residents' finances required improvement. All residents had assessments in place to determine levels of capacity and their required levels of staff support for the management of their finances. For some residents, family members were supporting them to manage their finances. At times, this posed difficulties and potential risks as some residents had no access to their accounts or had no account in their name.

Staff had completed additional training in infection control and the donning and doffing of personal protective equipment (PPE) due to the COVID-19 pandemic and staff were observed wearing PPE in line with national guidance on the day of inspection. Evidence that staff and management had communicated about the restrictions in place with residents in an accessible manner was observed. However, up-to-date guidance and information was not available to staff and residents in relation to infection prevention and control with the providers policy last reviewed in 2015.

Systems were in place to manage and mitigate risk in the centre and the inspector acknowledged that while they required improvement these had developed since the last inspection. Systems in place for review and oversight continue to require review. Where required, residents had a number of individual risk assessments in place to promote their overall safety and well being. While these were reviewed it was apparent that the content or whether they were still required had not been considered. A number of individual risks reviewed by the inspector were not considered risks, rather they were measures in place that impacted on residents' rights to make choices, such as using bad language if out in the community or dressing in a particular way. In addition, the detail in these risk assessments used references to the potential for residents to 'give a wrong impression' or 'getting into trouble'.

Regulation 17: Premises

The centre presented as a warm and homely environment. Each resident had their own bedroom which was decorated in line with their personal interests and tastes. Communal spaces such as kitchens and living rooms were clean and comfortable. There were schedules on display indicating residents were supported to carry out daily activities within their homes. While there were a number of areas that required repair and maintenance in the house the provider indicated these were not completed as an extensive refurbishment of the centre is due to commence shortly. This will include the building of an accessible bathroom and the creation of separate independent living areas within the house.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place to assess and manage risks in the centre, however, some aspects required improvement. For example, one resident had risk assessments relating to living in the second house under this designated centre where they had not lived for at least 10 months and this risk had been reviewed in March 2021 and was not amended or closed. Not all risks relating to COVID-19 had been reviewed for individual residents. General environmental risks were not being reviewed in line with the provider's policy with some indicating they had not been reviewed since 2010 and others since 2017. Where these other risks had been reviewed, the control measures in place were detailed and informed practice, such as supporting the volunteers within the community.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider and person in charge had not ensured that staff were guided in their practice by up-to-date documentation with the providers policy last reviewed in 2015. Staff checked their temperature at home prior to reporting for work and at the end of their shift. There was a single point of entry to the house with hand washing facilities available, the sink for hand washing was not clean on the day of inspection. Hand sanitising gels were available in the kitchen and at entry, but were not observed upstairs or at other points in the house. The shared bathrooms required attention to bring them to the same standard of cleanliness as the rest of the house.

Systems for the storage and disposal of PPE also required review. Clean supplies of

PPE were kept under the stairs and beside the bin for disposal of used PPE that staff had to handle to open as it was not operated with a foot pedal. Other household items such as vacuum cleaners were stored beside clinical waste.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had effective systems in place for the detection, containment and extinguishing of fire. There were fire doors in the centre fitted with self-closing mechanisms that were regularly reviewed and appeared in good working order. Fire escape routes and exits were clear of obstacles and clearly identified. Inspectors reviewed maintenance records and documentation showing that fire fighting equipment and the fire panel were serviced by an appropriately qualified professional.

Residents had personal evacuation plans in place, and drills were taking place although the recording of these, in particular the time the drill happened needed improvement and this was discussed on the day of inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need completed and care plans were developed as required. There was evidence that residents' personal plans were reviewed regularly and individual goals had been set or reviewed following these. While access to the community remained restricted due to the COVID-19 pandemic residents were supported to engage in activities in and around the centre.

Judgment: Compliant

Regulation 6: Health care

Systems were in place to ensure the healthcare needs of the residents were provided for. There was access to GP services (and other health and social care professionals), as required, which formed part of the service provided to residents.

Judgment: Compliant

Regulation 8: Protection

The provider had a safeguarding policy in place and procedures to guide staff on the reporting of concerns. There were two open safeguarding plans in the centre on the day of inspection. Inspectors reviewed these and noted that one had been reviewed and was to be closed as there were no further concerns. The other related to compatibility issues between residents which resulted in a safeguarding concern. This had been addressed in the immediate aftermath with one resident moving bedroom. This concern had been reported as required and an interim safeguarding plan developed. The measures required to support the resident on returning to their bedroom in an ongoing manner and for staff in supporting interactions between residents if necessary had been identified for inclusion in the formal safeguarding plan. However, as the resident was due to return to their bedroom in advance of the formal safeguarding plan being in effect, these measures were not available to guide staff and protect the resident in that period of time.

Management of residents finances required improvement. All residents had assessments in place to determine levels of capacity and their required levels of staff support in for the management of their finances. For some residents, family members were supporting them to manage their finances. At times, this posed difficulties and potential risks. Some residents did not have full access to their own money at all times and some had no bank card or any sight of their accounts or had no account in their name. Staff and management supporting the residents did not have oversight of the residents' spending, as an example they had no copies of bank statements, and therefore could not complete audits in line with the service policy.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had generally ensured that each resident, in accordance with their wishes, participated in decisions about their care and support. Residents were encouraged to sign documents for themselves that pertained to them where possible. There was evidence of some resident meetings taking place with information shared in these. While residents had the freedom to exercise choice and control in their daily lives there was evidence that in some situations they did not as outlined in the body of the report.

Judgment: Substantially 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	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Kingsriver Community OSV-0002410

Inspection ID: MON-0031024

Date of inspection: 09/03/2021

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: • Kingsriver will introduce a Quality Assurance System to ensure all HIQA related documentation (applications/notifications etc) are submitted in a timely fashion.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A full review and audit of all Schedule 2 documentation has been completed since the inspection and all prescribed information will be in place by the end of April.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Fire Training completed (26/3/21) • Kingsriver have a staff supervision (Quality Conversations) process in place. Training	

will be provided to all managers to ensure when performance issues are identified that staff get the support required. Kingsriver also have an Employee Assistance Programme in place which provides external support to employees if so required.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • 6 monthly audit report-Completed 31/3/21 • Quality Review- 9/4/21 • Complaint Audit-17/3/21 • Safeguarding-21/3/21 • Kingsriver have introduced a new Quality Assurance Process (Auditing) to ensure audits are planned, scheduled and conducted. This process will also ensure that all actions have clear timelines for competition.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • While all policies and procedures had been reviewed and updated in line with the recommended timelines at the time of inspection, out of date and older versions of policies were still in place within the designated centre. Kingsriver will introduce a Quality Assurance system to ensure that all reviewed and updated policies are distributed to all locations and that all previous versions are returned to the main office before circulation of the new policy. All staff will be required to confirm in writing that they have received and read the updated version of any policy & procedure.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Covid 19 risk assessments will be completed for all residents
• Risk Assessment related to a second house is now closed.
• General Environmental Risk Assessments will be reviewed, updated and closed where recommended.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• While the Infection & Control Policy (KRC019) had been reviewed (8/3/21) we will now update the policy to reflect and include the Kingsriver "Infection Control and Coronavirus Covid-19 policy (KRC019AD).
• Temperature Check recording form will be monitored by the PIC on a weekly basis.
• Cleaning schedule and tasks to be reviewed and monitored by the PIC. One staff member will be delegated to monitor and report any deficiencies re cleanliness etc to the PIC.
• Hand gels and sanitizes will be located at numerous points throughout the designated centre.
• Separate locations have been identified for the safe storage and disposal of PPE. Pedal bin now in place.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Interim Safeguarding Plan (3/3/21) approved by HSE safeguarding team in place at the time of inspection. Formal Safeguarding plan which was not required until (13/3/21) included support for the resident (as outlined in the report) was submitted, approved and date (14/4/21) set for review.
• A full review of financial oversight will be conducted by an external consultant to ensure the rights of the residents are being respected, their finances are managed safely and the organisation is fulfilling its regulatory obligations.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • All Risk Assessments will be reviewed, updated and closed if appropriate.	

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	30/04/2021
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	30/04/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	14/04/2021

	as part of a continuous professional development programme.			
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	16/04/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	28/05/2021
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	Not Compliant	Orange	30/04/2021

	support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/04/2021
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.	Not Compliant	Orange	16/04/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may	Not Compliant	Orange	23/04/2021

	require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/04/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	30/04/2021