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:	Carrick on Suir Camphill Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	08 December 2020
Centre ID:	OSV-0003608
Fieldwork ID:	MON-0031330

About the designated centre

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

Carrick on Suir Camphill Community, located in a town, provides long-term residential care to both male and female residents over the age of 18 with intellectual disabilities, autism and physical support needs who require medium levels of support. The centre comprises of seven units in total combining a mixture of residential houses and individual semi-independent supported houses. All residents have their own bedrooms and facilities throughout the units which make up this centre include kitchens, sitting rooms, dining rooms and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff (including a nurse and social care staff) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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 8 December 2020	10:00hrs to 16:00hrs	Conor Brady	Lead
Tuesday 8 December 2020	10:00hrs to 16:00hrs	Laura O'Sullivan	Support
Tuesday 8 December 2020	10:00hrs to 16:00hrs	Lucia Power	Support

What residents told us and what inspectors observed

On arrival for this unannounced inspection, inspectors were informed that there were 15 residents living in this centre. Inspectors had the opportunity to meet with and observe the care and support delivery to 13 residents over the duration of this inspection. In general, residents observed and spoken with were found to be safe, well cared for and supervised. Residents spoken with, told inspectors that they felt safe and well supported. Some residents commented about significant changes in the centre since the previous HIQA inspection and highlighted the new staff and new members of management specifically. Residents identified members of staff who supported them by name and members of management who they would go to if they had a problem or a difficulty. Many staff spoken with had a clear understanding of the support needs of the residents and referenced changes/improvements in the centre.

Inspectors noted a substantive improvement in the presentation of residents and the overall hygiene and cleanliness of the centre. The majority of the staff team and management had been changed in this centre since last inspected in June 2020 and there was a marked improvement in the basic areas of safety, quality and standard of care delivery observed on this inspection.

Residents appeared very comfortable in their homes and with staff on duty.
One resident spoke of feeling safe and knew that if they needed anything they could ask staff for support. Another showed the inspector where they kept the contact details of the people they would ring if they needed anything day or night. Residents personal space was individualised to their personal interests and hobbies. Residents proudly showed their art work and some craft activities to the inspectors and spoke of their enjoyment in music, reading and weaving. One resident was helping staff to clean up after lunch and told the inspector it was a job they always enjoyed. One resident requested a specific staff be rostered on with them and this was observed to be facilitated for this resident on the day of inspection.

Capacity and capability

Following a series of very poor inspection findings in centres operated by Camphill Communities of Ireland in 2020, the registered provider was required to submit a comprehensive national improvement plan by the Chief Inspector of Social Services. Due to the levels of concern found, substantive provider led improvements were required across all Camphill Communities of Ireland designated centres. This national improvement plan was submitted by Camphill Communities of Ireland in October 2020. Due to the seriousness of the regulatory concerns regarding both the capacity and capability of the registered provider and the quality and safety of care

and support delivered to residents, the implementation of this national plan is being monitored by the Chief Inspector on a monthly basis. This inspection formed part of this national monitoring programme of Camphill Communities of Ireland.

Given the serious concerns highlighted in the previous inspection of this centre, only the most pertinent areas of safeguarding and risk were reviewed as part of this risk based inspection. Retrospective safeguarding concerns were not reviewed as part of this inspection. Inspectors focus was primarily on the current safeguarding of residents on this inspection and the management of all risk and safeguarding incidents that had occurred since the previous inspection. This inspection took place during the COVID -19 pandemic so all public health guidance, social distancing and infection control precautions were adhered to by inspectors.

Overall the changes made by the provider in this centre were found to be improving the safety, quality and standard of care delivery to the residents. A new person in charge was in place who demonstrated fitness and had introduced and initiated many of the providers newly formed systems of auditing, oversight and accountability in order to ensure that resident's basic safety needs were now being met. The providers new Head of Service was playing an active oversight role in this service which was also found to be driving the required changes and improvements in this centre. This was evident in terms of monitoring care delivery, senior managerial oversight and audit, stakeholder engagement, communication and managerial review.

The provider had also commissioned an independent service review since the previous inspection. While the actions taken by the provider have resulted in many of the previous serious concerns being addressed, inspectors noted that many of the changes made were in effect 'brand new' with a number of other provider level plans yet to be implemented. For example, all aspects of the providers national improvement plan which were being monitored on a monthly basis by the Chief Inspector have yet to be fully implemented.

Ongoing local implementation and consistent regional and national managerial review of this implementation is crucial in this centre. This centre has undergone significant changes in a very short period of time hence the management, maintenance and sustainability of progress will be largely dependent on the provider implementing all aspects of the national improvement plan submitted to the Chief Inspector. Notwithstanding the progress achieved, the provider had not yet embedded all policies, reviews, action plans, completed assessments, audits, resource changes/requirements, staff training/supervisions. Furthermore the review and regularisation of all parts of this centre needed further attention on the part of the provider and needed to be amended and aligned to the centres statement of purpose and function. For example, part of the centre was identified as being 'not part of centre' by some staff and management and as part of the centre by others.

A resident had recently been transitioned by the provider out of the designated centre to a part of the provider's services that were not subject to regulation. Concerns regarding such a provider response were discussed with the Head of

Service and further information was sought and provided regarding this resident transition which included consultation with families. For example, a clear rationale based on transparent assessment as to why the protection of the regulations would not be provided to residents who were deemed by the provider only six months ago to require same. This ongoing assessment, review and regularisation should also take into account the removal/closure of parts of the centre not deemed to be currently suitable to the assessed needs of residents. This issue had also been identified in the independent service review commissioned by the provider (October 2020).

Since the previous inspection an internal review of staffing levels within all areas of the designated centre had been completed. This review included consultation with residents and promoted the safety of residents at all times. In some areas the review resulted in a change from sleeping night staff to waking night staff. Other changes in the staffing ensured that an effective handover procedure was now in place and that all relevant information was communicated within the staff team. An external review by the funding body was in progress which incorporated a comprehensive assessment of need to ensure that staffing levels and skill mix in place were appropriate to the assessed needs of the residents currently availing of the service within the centre. A national provider review of staffing was requested by HIQA as part of the providers national improvement plan and this has yet to be provided. An actual and planned roster was in place for each area of the centre, which now incorporated any specific delegated duties to be completed by the staff team such as cleaning or medication management audit.

The formal supervision of the staff team was the delegated duty of the house coordinators. Should an issue arise this information would disseminated to the person in charge. This was found to require improvement. While house coordinators were new to positions some had not completed any supervisions with staff members at the point of this inspection. This had been discussed as part of a management meeting and an action plan was in place to ensure that all staff received a formal supervision. All staff spoken with were aware of the governance structure within the centre including the lines of accountability and whom they would report any concern to. The person in charge had completed formal supervisions for all house coordinators and the deputy person in charge. This ensured that all members of the governance team were aware of and understood their roles and responsibilities.

As part of this inspection a review of current staff training records was also completed. The person in charge maintained a record of all mandatory training completed by the staff team including any refresher training. Some gaps were evident in the area of infection control including the use of personal protective equipment (PPE) and hand hygiene. Whilst a plan was in place to address outstanding training in the new year a number of staff required training in areas including manual handling and support in the area of behaviours of concern.

Overall good improvements were found on this inspection but a lot of work remained to ensure the full implementation and maintenance of these changes and improvements for residents.

Regulation 14: Persons in charge

A full time, qualified person in charge was in post and demonstrated the necessary skill and experience on this inspection.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had appointed a new staff team to the centre which appeared appropriate to the assessed needs of the residents on the morning of inspection. However a reliance on agency staff was evident whilst a review of staffing levels was "ongoing" both from an internal and external perspective to ensure the service provided was safe and effective at all times for all residents. In addition, as a lot of staff changes had occurred in this service consistency was yet to be fully embedded. As part of the providers national improvement plan a breakdown of the required staffing level (in all of their designated centres) based on the assessed needs of all residents was requested by HIQA - this has not been provided to date as requested. This is required before full compliance can be demonstrated in this area.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff members were yet to be fully facilitated to access all appropriate mandatory training including refresher training. Systems in place within the organisational staff supervision policy had yet to commence within the centre and all staff were yet to receive formal supervision.

Judgment: Not compliant

Regulation 23: Governance and management

Substantive improvements were found regarding the governance, operational management and administration of this centre. The Head of Services, Regional Manager and Person in Charge had completed a lot of work to move this centre towards compliance. Further improvements were however required to

fully implement all aspects of the registered providers national improvement plan, policies and procedures and to consistently maintain managerial oversight between person in charge, regional manager, head of service and registered provider. The overall effectiveness of the changes made will not be fully evident until the full implementation of the providers national improvement plan which concludes in April 2021.

Judgment: Not compliant

Regulation 3: Statement of purpose

Based on the findings of this inspection, the provider needs to complete a comprehensive review of the make up of the designated centre and regularise same. Management and staff understanding of which parts of the centre make up the designated centre required improvement. This review should coincide with residents assessments of need and any proposed closures of parts of the centre/properties. Revised applications should be made to the Chief Inspector (where necessary) regarding any proposed changes to the designated centre.

Judgment: Not compliant

Quality and safety

Overall, residents in this centre were found to be safe on the day of inspection. The centre was observed to be complying with public health guidance regarding the management of COVID-19. Houses that were inspected were all observed to be clean and well ventilated. Staff were observed to be engaging in frequent hand washing and the wearing of face masks. COVID-19 stations had been established, clearly signed access and exit points and adequate levels of PPE and hand washing facilities were readily accessible and available. This was hugely improved since the previous inspection.

Residents were observed to be supported to engage in activities and some were coming and going to various activities on the day of inspection. Staff spoken with were observed to be appropriately knowledgeable and were found to be pleasant and respectful to the residents in their care. Some residents were supported to gain meaningful employment, whilst others enjoyed attending local art groups. A number of residents had their art and craft projects on display. Staff and residents spoke of engaging in new activities within the local community in the new year when COVID-19 restrictions were reviewed. Residents told inspectors they missed accessing the community freely.

Inspectors found that the residents in the centre were appropriately safeguarded. The inspectors reviewed a series of notifications of concern submitted to the Chief Inspector since the previous inspection. Inspectors found that appropriate action had been taken by the provider on each occasion in terms of the reporting, recording and managing of each of the matters concerned. Residents current finances reviewed on the day of inspection were found to be appropriately safeguarded. Staff demonstrated good knowledge regarding the types of abuse, reporting procedures and it was clear that a substantive amount of work had gone into education and overall improvements in the area of safeguarding and abuse in the centre (in a short period of time). The provider noted that a 'culture change' to how safeguarding was viewed by staff and management alike was required and that this is very much the approach that is taken now in the centre. The providers overarching plans regarding resident contracts, financial management and access to finances was still in process, but progress had made since the previous inspection. However full implementation across all parts of the centre is still required to ensure full adherence to regulatory requirements.

Risk management in the centre had substantially improved in a number of areas, with many risks now found to be clearly identified and escalated on the centres risk register. A quality and safety lead had evidence of auditing in place that supported the person in charge. However, some auditing and risk assessments remained outstanding in key areas for example, fire safety. This was reportedly scheduled for the week following this inspection. Staff members in one area of the centre were unaware of some risk areas and the control measures that were in place. Due to the remit of the house coordinator assigned to this area this information had yet to be disseminated to staff. As formal supervision with staff had not been rolled out, coupled with the amount of change and new staff this was determined to be a continued risk.

Overall the serious breaches in quality and safety found in June 2020 had been addressed by the provider and clear action plans were found in place to move the centre towards compliance with the regulations once fully implemented.

Regulation 13: General welfare and development

Residents were found to be well engaged and supported on the day of inspection. Residents and their environs all presented as clean, warm, well dressed and appropriately supported on this unannounced inspection.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriately clean and all previously identified issues with part of the premises had been addressed in terms of residents bedrooms, bathrooms and the general hygiene and cleanliness of the centre as a whole.

However as identified in the providers own independent service review (October 2020) parts of the premises were not deemed to be 'fit for purpose'. One area of the centre in particular while in a suitable location was not adjudged to be suitable or in line with residents assessed needs in terms of layout, suitability or as a positive living space. The upstairs of this part of the premises has been assessed as 'unsafe' so is 'out of bounds for the resident'. The resident is over 6ft tall and the cottage has low ceilings and door frames requiring him to crouch and stoop everyday to move through his home.

Judgment: Not compliant

Regulation 26: Risk management procedures

Positive and substantive improvements in risk management were evident on this inspection. However further demonstration of auditing in key risk areas and ensuring all staff are fully aware of all key risks in the centre was required.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Appropriate systems and practices were found in place regarding protection against infection. Substantive work in this area had been completed since the previous inspection.

Judgment: Compliant

Regulation 8: Protection

Residents were found to be safe on this inspection and wholesale improvements had been made regarding this area in terms of the current safeguarding practices that were operational in the centre. The providers overarching plans regarding resident contracts, financial management and access to finances was still in process (in some cases reviewed) but progress had made since the previous inspection. However full implementation across all parts of the centre is still required to ensure full adherence to regulatory requirements. Inspectors did not review any retrospective

safeguarding matters as part of this inspection.
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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Carrick on Suir Camphill Community OSV-0003608

Inspection ID: MON-0031330

Date of inspection: 08/12/2020

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • In line with The Organizational Action Plan the Service Provider has completed a roster review on 04/11/2021. • The HSE have undertaken an independent assessment of Community Members and their support requirement as part of a validation of current staffing and funding requirements, findings are pending. • The PIC has requested a number of vacant posts be filled. As of the 01/02/2021 the number of agency staff used to support rostered shifts will be one (1) agency staff member. By the 28/01/2021 it is envisaged that no agency staff will be used to fill core rostered shifts within the Centre. • A recruitment program is underway to recruit 4 remaining vacant posts, it is envisaged that these posts will be filled by 31/03/2021 further increasing continuity of staff.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A National learning & development officer has been recruited and is now in post to co-ordinate training and development for all CCoI staff, • The PIC has conducted a full review of all supervision structures required for all staff	

and has developed 2021 Supervision Schedule for each staff has received a number of assigned dates for supervision.

• In line with the Organizational Action Plan, House Coordinators have assumed responsibility for the scheduling of their respective staff for supervision for the year 2021. The PIC has assumed and scheduled supervisions dates for each House Coordinator respectively for the year 2021, each staff member has also been assigned an appraisal date.

• A comprehensive supervision Schedule has been planned for the year, the first scheduling of supervision has already commenced, by 5/02/21 all staff will have received formal supervision.

• A full review of HR and training files has been completed by the PIC, a training schedule has been planned for the year 2021 ensuring all mandatory training & refresher training will be scheduled. All staff will be trained in mandatory training by 30/03/21. This date should be brought forwards.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• In line with the Organizational Action Plan, the Service Provider will implement a schedule for unannounced inspections. A schedule of annual reviews has also been developed with the last annual review for the center completed in December 2020.

• A governance and communication structure has been developed within the center ensuring oversight, review of quality and safety, participation and learning, this consists of structured meetings at house and community level with the, regional manager and regional leads from clinical and safeguarding attend at least one predetermined monthly meeting providing support & advice. A visual meeting schedule has been developed within the center.

• All Community members have been offered a new residential contract and have signed those. An external mediator working with 2 community members with nonstandard payments will regularize the schedule of fees with these people by mid March

• All Community Members have been assigned an annual review date; a developed list of dates is under review by the PIC ensuring compliance. The PIC has also implemented a series of dates that include two Circle of Support meeting per year with family and advocates, ensuring inclusion, active participation with support plans, choice, and opportunity, the PIC holds a list of dates ensuring meetings occur.

• Each resident has in place a "My Day My Week" schedule outlining what a day and week looks like for Community Members. This is measured and reviewed on a daily basis by the PIC using "daily logs". All daily logs are digitalized and securely stored in a cloud system.

• Each Community Member has received a finance review and risk assessment review of finance by the PIC. The PIC is currently engaged in implementing the new CcoI CMSN Money and Personal Possessions Policy, each resident will have had a money management assessment by 15/02/2021 outlining their level of support and independence to make safe decisions in financial matters.

• Each resident has in place a personal possession list, as of the 01/02/2021 all financial matters will be recorded digitally on this Asset register. Any purchase of an item over €50 deemed an asset will be recorded on the digital asset list. The PIC has full oversight of all financial transactions in real time, daily monies held by the Community Members in their wallets/home is recorded in the "daily log".

• A monthly Personal finance form is used online for each resident to daily log cash in hand and any transaction and expenditure by the House coordinator. This is reconciled on a monthly basis and checked by the PIC/Admin staff.

• The monthly Personal finance forms are subject to random auditing by the new CMSN's finance officer…

• The Head of Service, Quality and Safety Lead, Regional Manager and PIC are proactively working through the Organizational Compliance action Plan and expects full implementation by 31 April 2021. The PIC is supported monthly by the RM through supervisions.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

• An application to vary the living space and the sleeping quarters of Deaglon House will be submitted by 30/03/2021. The changing of the space will define the Statement of Purpose to reflect more appropriately the new center layout.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Service Provider has initiated an independent report into part of the designated center, the findings of the report concluded "part of the designated center is not fit for purpose, report completed October 2020.
• The resident currently residing in the part of the center deemed not appropriate is engaged in extensive dialogue to transition to a more suitable home and location closer to family.

• Several meetings have taken place with the wider family in support of a transition, next meeting is due for week commencing 7/02/2021.

• A business case to secure greater funding from the HSE has been completed to ease and secure the supports required for a transition to a new permanent home.

• Internal inquiries into vacancies in other Camphill Communities preferred by the Community Member and family have not been successful due to no vacancies.

• The week commencing 7/02/2021 a meeting to establish other alternatives such as, renting, CAS supports will take place.

• Once the transition has occurred it is the intention of the Service Provider to deregister the part of the designated center deemed not appropriate for use.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A National Quality and Safety Lead, Health & Safety Manager is in place supporting the center, a Quality and Safety Lead has also been in post within the center since October 2020.

• The Organizational Risk Register and the Local Centre Risk Register are discussed at all Management Meetings and remain an agenda item.

• Risks are reviewed quarterly between the PIC and the House Coordinator and or after all reported incidents and learning discussed at management meetings.

• A current review of risk assessment is underway by the PIC and will be completed by 11/02/2021.

• All accidents and incidents are discussed in the Community management meetings and

support by RM, regional safeguarding lead and clinical support officer is provided once a month.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• A new CMSN Finances Policy is being rolled out in the center with full implementation by 28/02/2021.

• All Community Members finances are reviewed daily and are recorded digitally from 01/02/2021 providing the PIC with real time data and oversight.

• All monies kept on hand by the Community Members are checked and recorded daily in the "daily logs" which is reviewed daily by the PIC.

• Daily reconciliation by House Coordinators on receipts is in place across the center on the monthly Personal Finance form on Sharepoint.

• Monthly audits of finances by Quality & Safety lead is in place.

• A new money management assessment format for all Community Members is underway within the center and will be completed by 11/02/2021.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	01/03/2021
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.	Not Compliant	Orange	01/03/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	05/02/2021
Regulation 17(1)(a)	The registered provider shall ensure the	Not Compliant	Orange	30/06/2021

	premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2021
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	30/04/2021
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	30/04/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	28/02/2021

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	05/02/2021