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:	Ashington Group - Community Residential Service
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 7
Type of inspection:	Short Notice Announced
Date of inspection:	07 April 2021
Centre ID:	OSV-0003979
Fieldwork ID:	MON-0027087

About the designated centre

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

The Ashington Group consists of three community based homes and is part of the Daughters of Charity community services that provides a high level of support and care to up to ten people with intellectual disabilities. The community houses are situated in quiet residential areas. All residents living in Ashington Group have single occupancy bedrooms. All three houses have communal bathroom, kitchen, dining and sitting room areas and rear facing gardens. The three houses are long stay residential homes which are open 24 hours a day, seven days a week. They are staffed by a clinical nurse manager, staff nurses, social care workers and health care assistants. The staff in the Ashington Group strive to provide a homelike environment where each persons individual needs are identified and met. Staff support residents to attend day services or individual activities daily.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 April 2021	09:30hrs to 15:30hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

From what residents told us and what the inspector observed, individuals who were living in this centre were experiencing a good quality of life and were generally well cared for and supported. Despite this, the inspector found that the centre was not managed well and there was a significant need for the improvement of services in order for the registered provider to come into compliance with the regulations. This inspection identified high levels of non-compliance across a number of core areas and these findings are outlined in the body of this report.

The inspector met with seven residents on the day of the inspection and spent time observing the care and support which was being provided to them. In addition, the inspector spoke in detail with one resident about their experience of living in the centre and standard of supports they were in receipt of. The inspector observed that residents were supported in a timely manner and that staff members were attentive and sensitive in their approach. A resident spoken with in detail told the inspector that "the best thing about the centre is the staff" and explained that they felt safe in the centre and knew what to do if they ever had a concern. The resident explained that they had a personal plan in place and informed the inspector about their goals and objectives for the coming year which included celebrating a significant birthday, going on holidays, going to a concert and reading more books in the local library.

While some of the residents were aware of the COVID-19 pandemic and the associated restrictions, others were not aware of these. Those that were aware explained to the inspector that they felt frustrated and were looking forward to the lifting of the restrictions. Despite this, the resident group were leading relatively active lives and engaging in adapted activities. The range of activities offered to residents during the COVID-19 pandemic included baking, cooking, listening to music, arts and crafts, jigsaws, having hair and nails attended to by staff members, foot spa, walks in the local area, exercise classes and going for take away coffees. While these activities reflected an overall reduced offering, it was clear that the staff team had made considerable effort to ensure a person-centred and creative approach during this time. For example, one resident told the inspector that while they were unable to go to the local shop themselves, a staff member went for them and took a picture of all the magazines and papers that were available and that way the residents could pick which ones they wished to purchase.

The inspector received seven completed resident questionnaires which had been provided to the registered provider in advance of the inspection. The questionnaires asked for participant feedback on a number of areas including general satisfaction with the service being delivered, bedroom accommodation, food and mealtime experience, arrangements for visitors to the centre, personal rights, activities, staffing supports and complaints. There was mixed levels of satisfaction outlined in the completed questionnaires and while residents stated that they were happy with the service they were in receipt of there were some areas identified as requiring improvement. One resident stated "I am doing lots of activities at home now

especially due to COVID-19 restrictions but I am enjoying all these activities" while another stated that "we don't always have regular staff and I get anxious when staff don't know my routine". Another resident similarly stated that "I feel safe and secure when familiar staff are on duty but I find it difficult when relief staff are not familiar with me".

The inspector spoke with three family members of the residents by phone after the inspection and found that overall, they were very happy with the standard of the services being provided in the centre. They told the inspector about the difficulties associated with COVID-19 restrictions and not being able to see their loved ones for such an extended period of time. One family member told the inspector that the staff team "...go out of their way to make things very easy for you" while another said that the residents were "very safe and well looked after". A family member told the inspector that there were at times some difficulties in securing the input of some allied health professionals where it was required and on occasions there was some lack of clarity in the communications from the management team.

The centre is made up of three houses in two different settings. In the first setting there are two semi-detached houses with a shared front garden and a joined conservatory area to the rear along with a shared patio outdoor space. This setting provides accommodation for up to three residents in one house and four in the other. In the second setting a detached house provides accommodation for up to three residents. The inspector visited just one setting during the course of the inspection due to public health guidance and found that overall, the premises of that setting were in a poor state of repair and required significant improvements. The inspector found that in one house there was limited space for residents to relax and to spend time socially. The inspector observed adhesive tape applied to walls to hold plaster in place that was falling from the walls, tape applied to floors to cover damaged patches, worn and damaged furniture in a number of rooms, outdoor spaces were not level and presented a clear risk to persons with reduced mobility, door frames damaged, a considerable number of rooms required painting and decoration, curtain poles falling from walls, and conservatory roof requiring cleaning. In addition, the kitchen in one house was in a poor state and required replacement.

There was clear evidence to demonstrate that residents had been supported to exercise their rights while living in the centre. There were weekly resident forum meetings taking place and each resident had been appointed a key worker. Residents had input on menu and activity planning and were supported to develop an understanding of issues which impacted them such as the COVID-19 pandemic. Residents had been supported to open their own bank accounts and to have debit cards for day-to-day use. Each resident had their own bedroom and staff were observed knocking before entering these areas. There was an intimate care policy in place in the centre and every resident had an intimate care plan developed. While overall, the inspector found that a respectful and dignified culture had been created there remained some areas for improvement. For example, staff members told the inspector that a resident who required support with their mobility was required to use a toilet commode to transfer within the first floor environment due to the lack of appropriate equipment in this area. The inspector found that this was not appropriate and did not promote the dignity of some residents. In addition, there

was an absence of an accessible toilet on the ground floor of this house which meant that some residents had to use a stairs lift to gain access to the main bathroom on the first floor.

The inspector found that overall, the absence of appropriate governance and management arrangements were impacting negatively on a number of key areas including staffing, training and development, the premises of the centre, the management of risk, and fire safety. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The inspector identified high levels of non-compliance with the regulations during this inspection and it was clear that there was a need for significant improvement including the development and implementation of good governance arrangements. There was an absence of appropriate oversight of the care and support being delivered in the centre and while there was some evidence to demonstrate person-centred approaches, the inspector found that these were being steered by individual staff members in the absence of appropriate supports from the registered provider.

The centre was managed by a person in charge who was employed in a full-time capacity. They reported to clinical nurse manager who in turn reported to a service manager. While the inspector found that the management structures were clear, there was a lack of leadership in the centre which resulted in the absence of clear direction for the staff team. There was an overarching absence of developed management systems to allow the centre operate to a high standard or to achieve its objectives. In addition, the provider had failed to collect information from residents and their representatives to inform the improvements required in the centre. For example, an annual review of the service completed in the days preceding the inspection failed to consult with residents or their families on their experiences of living in the centre. The inspector also found that actions arising from a six monthly unannounced visits to the centre by the registered provider in September 2020 had not been followed up on. This demonstrated that the registered provider was not effective in promoting quality improvement in the centre. The provider had also failed to complete an annual review for 2019 as required by the regulations.

While the inspector found that the centre was appropriately resourced, there was ambiguity as to what the agreed allocation of staffing resources was. The centre was operating at a deficit of 2.16 full time equivalents (or approximately 84 hours per week) when the staff duty rosters were compared to the statement of purpose (dated January 2020) used to support the application to renew the registration of the centre. There was a lack of awareness of this deficit on the part of the

registered provider and an explanation as to the reasons for this variation or reduction was not available to the inspector. In addition, there were concerns regarding the continuity of the care and support being provided in the centre. A review of a sample of staff duty rosters found that between 18 and 22 per cent of the staff team was made up of relief staff members. It was not possible for the inspector to ascertain whether the same relief staff members were working in the centre as the staff duty rosters did not in many cases outline the names of relief staff.

Regulation 15: Staffing

The inspector found that the registered provider had not rostered the number of staff members it had committed to in its statement of purpose (dated January 2020). While the skill mix of the staff team was found to be appropriate to meet the needs of residents, there was a considerable reliance on relief staff to support the core staff team. This, the inspector found, demonstrated that care and support was not continuous and was found to be a cause of anxiety for the resident group. Staff duty rosters maintained in the centre did not include the person in charge's shifts, did not identify who the shift leader was in the absence of the person in charge, did not include a key for a number of codes used in the documents, did not include the grades of a number of staff members, and did not list the names of a number of agency and relief staff members who worked in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector found that there were a number of deficits in staff training courses described as being mandatory by the person in charge. These included fire training, food safety, medication management and safeguarding. The arrangements in place for the supervision of the staff team were not satisfactory. For example, a team meeting had not taken place since November 2020 and only three staff members of a team of approximately 22 had received a supervision meeting with their line manager.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that there was appropriate oversight of the

care and support being delivered in this centre. The governance and management arrangements in place were not satisfactory. There was a need for the development of robust management systems to ensure that services provided were appropriate to the needs of residents and effectively monitored.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of incident, accident and near miss records maintained in the centre and found that required notification of incidents to the Chief Inspector had been completed as per the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector found that the registered provider had established and implemented effective systems to address or resolve issues raised by residents, their representatives and other stakeholders. There was a complaints register maintained in the centre and there were easy read procedures on making a complaint on display in the centre. There was a complaints officer appointed and residents told the inspector that they were aware of how to make a complaint.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents were supported and encouraged to have a reasonably good quality of life while residing in this centre. There was evidence to demonstrate that residents were consulted with and had been informed and supported to exercise their rights where possible. There were opportunities for social engagement and residents were supported, where possible, to develop the self-awareness, understanding and skills required for self-care and protection. However, the inspector identified a number of concerns and areas of non-compliance with the regulations including the physical environment and state of repair of the centre, the management of risk and fire safety concerns. These areas required significant improvements and developments to ensure that the safety of residents, staff and visitors was appropriately managed.

The inspector found that the systems employed to manage risk in the centre were not appropriate and were not effective. While there was a risk management policy in place, the inspector found that there was limited oversight of the management of risk in the centre. For example, the centre's risk register did not contain all risks and excluded resident related risks and COVID-19 associated risks. When the person in charge was asked about resident related risks, they informed the inspector that they would have to check each individual resident's personal plan folder to confirm what risks had been identified, assessed or managed to date. As a result of public health guidance, the person in charge was operating from only one setting of the centre and had not been present in the second setting since the onset of public restrictions associated with the pandemic. As a result, the person in charge or the management team did not have oversight of the risks associated with the residents who lived in the second location. In addition to this concern, the inspector found that some significant risks had not been assessed or managed appropriately. For example, in some cases the registered provider had not considered the evolving needs of residents and the risks associated with this during an evacuation of the centre.

While the registered provider had installed fire containment measures in the centre and had both a fire alarm and detection system and emergency lighting in place as required, the inspector found that there was a requirement for the consideration of the evolving support needs of residents and the manner in which they were to be evacuated from the centre in the event of a fire. The inspector issued an immediate action to the registered provider on the day of the inspection as there was an absence of evidence to demonstrate how at least one resident could be safely evacuated from the centre in the event of a fire or similar emergency. The registered provider submitted a number of assurances on the day after the inspection including the temporary relocation of a resident's bed, the completion of a fire drill, the completion of a risk assessment and an allied health professional meeting being held.

Regulation 17: Premises

The inspector found that one setting of the centre was not appropriate for the provision of residential services in it's current condition. As previously mentioned, this setting was in a poor state of repair both internally and externally. In addition, the layout of the centre did not meet the needs of the number of residents who were residing there and areas of the building which included a bathroom and bedrooms were not easily accessible to some residents who required support with their mobility.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was limited oversight of the management of risk in the centre. Some hazards and risks had not been identified or assessed by the registered provider. The systems used to manage risk were not appropriate or effective.

Judgment: Not compliant

Regulation 27: Protection against infection

The inspector found that the staff team were wearing personal protective equipment (PPE) in line with public health guidance and there were sufficient hand sanitizing stations in the centre. There were good levels of PPE available in the centre and there was a COVID-19 outbreak management plan in place. There were local policies and guidance documents in place also, however, the most recent version of some national guidance documents was not in place and as a result was not guiding staff practice.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had failed to make appropriate arrangements for the evacuation, where necessary in the event of a fire, some residents which increased mobility needs who were living in the centre. This finding resulted in an immediate action being issued to the registered provider.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that staff members spoken with had a good understanding of the various types of abuse and the actions required if they witnessed, suspected or had an abusive incident reported to them. Residents told the inspectors that they felt safe living in the centre. There was a safeguarding policy in the centre and the inspector found that this was informing practice. A number of incidents of a safeguarding nature had occurred in the centre and these were found to have been appropriately followed up on and managed by the registered provider.

Judgment: Compliant

Regulation 9: Residents' rights

While the inspector found that in the majority of cases residents were treated with dignity and respect, this did not extend to all residents. The arrangements for transferring a resident who required support mobilising on the first floor of the centre were found not to be appropriate. A toilet commode (ordinarily used to support residents use the bathroom and when providing intimate care) was used by staff to support a resident transfer for a stairs lift to their bedroom and to the bathroom due to the absence of an appropriate wheelchair.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ashington Group - Community Residential Service OSV-0003979

Inspection ID: MON-0027087

Date of inspection: 07/04/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC has revised the Statement of Purpose to reflect the required staffing for the designated centre. The Provider is recruiting specified purpose contracts to cover gaps in rosters due to maternity leave. This will ensure continuity of care. The planned and actual rosters have been revised to reflect the full name of all staff members, relief/ agency staff, to identify the shift leader, the staff grade and the location of the PIC with in the designated centre. A code for abbreviations is also on the roster.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 4 staff from the Ashington team to complete fire training. This will be completed by 30 May 2021 All other staff fully trained. 5 staff from Ashington team to complete food safety training. This training will be completed by 30 May 2021. All other staff have completed this training. All staff nurses have completed HSEland medication management training.	

All other staff who administer medication have completed a medication management course or refresher course.

All staff have completed both Children First training and Adult Safeguarding training.

The Manager has completed the Hseland supervision training on line to supplement previous supervision training.

The Manager is commencing a course on Regulation and Managing an Inspection on 5th May 2021.

The manager has devised a schedule for formal supervision for all staff in the designated centre.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider has established Governance and Oversight group which is chaired by the ACEO. This group are responsible to ensure that all actions identified in the HIQA report are completed in line with agreed timeframes.

The PIC has registered for a course on Regulation and how to prepare for an Inspection and this will commence on 5th May 2021.

The PIC has completed the HSEland supervision training on line.

The manager has devised a schedule for formal supervision for all staff.

The PPIM will continue to provide regular supervision with PIC.

The PIC has a schedule for team meetings monthly with staff teams for remainder of the year.

The Provider will ensure that The Annual Review is completed yearly and that both residents and families are consulted as part of this process.

Service user surveys have been circulated to all residents and staff will support them to complete same. The PIC and the PPIM will review surveys on return and action any concerns raised.

Family satisfaction surveys will be circulated to all families and on return the PIC and the

PPIM will review same and action any concerns raised.

The Provider will review the process of the 6 monthly provider visits and ensure that they are appropriately completed and within required time frames.

The PIC will action any recommendations from the reports. The PPIM will over see this.

The PIC will maintain an action log to ensure oversight of all actions from provider visits, annual review and HIQA inspections.

The PIC and PPIM will review actions and update the Service Manager on a monthly basis.

The Service manager, PPIM and night managers will visit the centre to ensure that actions have been completed.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider arranged for the maintenance Department to complete all the minor maintenance issues in the houses. This is complete.

A deep clean is being carried out in the designated centre.

The conservatory is being cleaning both inside and outside.

The Director of Properties, Estates and IT and the Maintenance manager have reviewed the centre and have arranged for painting works, flooring and renovations to the garden to be completed the week of the 17th May 2021.

The Provider had assessed the furnishings and kitchens in the centre and a schedule of replacement had been agreed.

An Individual Needs and Preference Assessment (IPNA) will be carried out with each resident to determine their needs and preferences in relation to their living environment.

The Director of Properties, Estates and IT, the ACEO and the Service Manager will carry out a full review of the premises in relation to the assessed the needs of residents going forward. Based on this a long term plan will be devised for the property.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PPIM has completed Risk management training

The PIC will complete Risk management training.

The Service Manager and PPIM with assistance from the Quality and Risk Officer will schedule risk management training for all staff in the designated centre.

The PIC and the PPIM will review all current risks in the Centre to ensure that appropriate controls are in place.

All risks will be reviewed on an ongoing basis.

The PIC will maintain a risk log and a risk register for the centre.

The PIC and PPIM have reviewed all the PEEPs to ensure safe fire evacuation for all residents. Alternative aids to evacuate are being trialed currently with one resident.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Provider will ensure that all up to date guidance on visits/ IPC is circulated to all staff to guide their practice.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC and PPIM are currently reviewing all the PEEPs to ensure safe fire evacuation for all residents. Alternative aids to evacuate are being trialed currently for one resident. The resident had been relocated in the designated centre until this is complete to ensure safe evacuation.

A number of Fire drills have been carried out and all residents are evacuating in a timely manner on 27/4/21.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: An MDT was held for one resident and a wheelchair is available for transfers if required.	

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.	Not Compliant	Orange	30/07/2021
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	30/07/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	03/05/2021

	showing staff on duty during the day and night and that it is properly maintained.			
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	30/05/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/07/2021
Regulation 17(1)(a)	The registered provider shall ensure the 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.	Not Compliant	Orange	01/09/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	14/06/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre	Not Compliant	Orange	01/10/2021

	adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	01/09/2022
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	Red	14/06/2021
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	01/01/2022

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	02/05/2021
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.	Not Compliant	Red	14/06/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting	Substantially Compliant	Yellow	03/05/2021

	procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
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	Red	19/04/2021
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	03/05/2021