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:	No.5 Stonecrop
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	17 August 2022
Centre ID:	OSV-0005144
Fieldwork ID:	MON-0031499

About the designated centre

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

No 5 Stonecrop is located in a suburb on the outskirts of Cork City. The centre is located close to public transport services, shops and recreational services. The service is based on a social care model and provides a full residential service for adults with moderate to severe levels of intellectual disability, some of whom are autistic. The centre can accommodate four residents.
The focus of the centre is to understand and meet the individual needs of each person by creating as homely an environment as possible. Individuals are encouraged to reach their fullest potential by participating in leisure, social and household activities.
The centre is a two-storey house with a parking area at the front of the property and a secure garden area at the rear. Located on the ground floor, there is a kitchen, separate dining room, sitting room and one bedroom with en-suite bathroom. The first floor comprised four bedrooms, a shared bathroom and an office.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 17 August 2022	09:10hrs to 17:45hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

The designated centre was a five bedroom, two-storey house in a residential area on the outskirts of Cork City. The centre was registered to accommodate four adults. Each resident had their own bedroom. One bedroom, with an en-suite bathroom, was on the ground floor, the other three residents' bedrooms were upstairs. Residents also had access to a living room, dining room, kitchen and communal upstairs bathroom. This bathroom had been renovated in recent months. There was a patio area and enclosed garden behind the house where residents enjoyed spending their time. There was also a staff bedroom and an office in the centre.

This was an unannounced inspection. On arrival the inspector met with one member of staff and two residents. The person in charge was on leave at the time of this inspection. The inspection was facilitated by the social care leader, who worked full-time in the centre, and one of the provider's senior managers. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

The centre was observed to be clean and decorated in a homely manner. Residents had been supported to decorate their bedrooms in line with their own personal tastes and preferences. One resident chose to lock their bedroom, however was happy to show it the inspector. There were photographs and artworks on display throughout the centre. Painting was required in some areas. A treadmill was available in the living room area and one resident spoke with the inspector about using it, as well as going for walks locally and with relatives. The house was well furnished and had two televisions in communal areas.

Residents enjoyed a good quality of life living in the centre. They were familiar with, and regularly spent time in, their local community. They participated in a number of activities aligned with their interests. Each resident received person-centred care from a dedicated staff team.

One resident had spent a number of months living with their family during the pandemic, returning to centre over a year ago. There were three residents in the centre on the day this inspection. The inspector had an opportunity to spend time with each of them. A fourth resident was spending some time with relatives in their family home. Residents enjoyed living in the centre and with each other. This was observed by the inspector and reported by members of the staff team and some of the residents themselves. Not all of the residents were verbal communicators, with some using Lámh (a sign system used by children and adults with intellectual disability and communication needs in Ireland) and other communication aids. A total communication approach was implemented in the centre. Visual supports were on display and available throughout the centre. Staff were observed using Lámh when communicating with residents and the positive impact of this in ensuring

residents' understanding was evident.

Two residents attended day services on the day of inspection, while a third was on a rest day as part of their retirement program. While in the centre, this resident was involved with day-to-day activities such as laundry and cleaning their bedroom. They also went to a local café with a staff member. Staff explained that the residents were regular customers of this café and that, even when busy, a table was always found for them. This resident appeared very comfortable in the centre and with the supports provided by staff.

The inspector spent some time with another resident before and after they attended their day service. This resident was very familiar with their routine and this appeared very important to them. A number of staff had spoken with the inspector about the importance of a consistent staff team and continuity for this resident. This resident also appeared at ease in the centre and with the staff team who clearly had a very good understanding of their support needs, preferences and personality.

The inspector met with the third resident when they returned from day services. This resident expressed how happy they were living in the centre and spoke with the inspector about their interests, activities that day, the evening meal, a planned visit to family members and other people who were important to them. They were due to have a massage in the centre that afternoon and were very much looking forward to it.

Although the inspector did not meet with residents' relatives as part of this inspection, feedback they had provided as part of the annual review was reviewed. This feedback was very positive with staff described as 'very approachable' and 'very helpful', and praise given to the high standard of care and support provided.

All interactions observed between staff and residents were respectful, warm and unhurried. Staff clearly had a very good awareness and understanding of each resident's communication style and tailored the supports they provided to each individual.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the three most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. The inspector also looked at records regarding staff training and any adverse incidents that occurred in the centre. The centre's risk register was reviewed and while comprehensive and recently reviewed, further revision was necessary to ensure that the risk assessments were accurate and reflective of the centre. The inspector also looked at all four residents' individual files. These included residents' personal development plans, healthcare and other support plans. These were generally of a good standard. Areas for improvement were identified and will be outlined in more detail in the remainder of this report.

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 to each resident living in the centre.

Capacity and capability

Overall, good management practices were in place. The provider adequately resourced and staffed the service. Both a proactive and responsive approach was taken to managing the centre. There was evidence of reflection and learning from incidents to improve the quality of life of residents. Management systems ensured that all audits and reviews as required by the regulations were completed. However, some audits assigned by the provider had not been completed in full or at the frequency outlined in their own policies and procedures. The centre was staffed by a committed, well-trained and consistent team.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. All support staff reported to the social care leader who worked in the centre on a full-time basis. They reported to the person in charge, who reported to a sector manager, who reported to the director of services. The social care leader was very knowledgeable about the residents' assessed needs and the day-to-day management of the centre. They told the inspector that they felt supported by management in their role and had regular formal and informal contact with the person in charge. As outlined in the opening section of this report, the person in charge was not available on the day of inspection.

The social care leader had some protected supernumerary time and also worked alongside their colleagues providing direct support to residents. Staff meetings were held regularly and one took place during this inspection. A one-to-one supervision schedule had been drawn up for the year and there was evidence that this was being implemented. These systems facilitated staff to raise concerns about the quality and safety of the care and support provided, if necessary. Members of the staff team who spoke with the inspector emphasised the culture of reflection and learning in the centre.

The provider had completed an annual review and unannounced visits every six months to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in December 2021 and involved consultation with residents and their representatives. Unannounced visits had taken place in April 2021, November 2021 and again in May 2022. Where identified, there was evidence that actions to address areas requiring improvement were being progressed or had been completed.

The provider had devised its own schedule of audits to be completed in the centre. The inspector reviewed a sample of these. While some had been completed in line with the provider's own policies and procedures, others had not. For example, a fire

safety audit was signed and dated however items were only marked as complete on one of the six pages in the audit document. Similarly, it was documented that medication audits were to take place four times each year. These audits were not occurring at this frequency, with one completed in March 2021 and another in April 2022. The inspector sought clarity regarding an audit to be completed by the person in charge across the year that covered many areas of care and support in the centre. Management advised that this audit was introduced in October 2021 and that the associated processes and procedures were under review by the senior management team.

The inspector reviewed the records maintained regarding adverse incidents in the centre. The person in charge had ensured that notifications regarding all incidents that were required to be notified within three working days had been submitted. However, it was identified that the use of one restrictive procedure in April 2022 had not been reported, as is required by the regulations.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. Initially the most recent version of this document was not available in the centre. This was provided during the inspection. This document met the majority of the requirements of the regulations. Some revision was required to ensure that the staffing arrangements and other information reflected the residents' return to day services and that an accidental reference to another designated centre was removed. The inspector assessed that staffing was routinely provided in the centre in line with the staffing levels outlined in the statement of purpose.

There was evidence of good oversight of staff training in the centre. Staff had access to appropriate training, including refresher training. All staff had recently attended the trainings identified as mandatory in the regulations. It was also noted that all staff had completed Lámh training with two newer recruits to the team scheduled to complete this in the coming month.

Regulation 15: Staffing

The number and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. Residents received continuity of care and support from a consistent staff team. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had recently attended the trainings identified as mandatory in the regulations. In addition, staff had access to training aligned to residents' individual needs.

Judgment: Compliant

Regulation 23: Governance and management

The provider had sufficiently resourced the centre to ensure the effective delivery of care and support. There was a clearly defined management structure and effective management systems in place. An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed. There was evidence that where issues had been identified, actions were completed to address these matters. It was noted that not all of the audits scheduled by the provider were completed in full or at the frequency identified in their own policies and procedures. Some document management systems in the centre also required review.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure all information was up to date and accurate following the residents' return to attending day services. It was also required that the most up-to-date version of this document was available to residents and their representatives in the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The use of a restraint procedure in the centre had not been notified, as is required by this regulation.

Judgment: Not compliant

Regulation 34: Complaints procedure

No complaints had been made recently in the centre. Systems were in place should they be required. Information regarding the complaints process was available in the centre.

Judgment: Compliant

Quality and safety

The inspector found that the quality of care and support provided was maintained to a high standard. A review of documentation and the inspector's observations indicated that residents were safe, their rights and independence were promoted, and they enjoyed living in this centre. Some areas where improvement was required were identified and these will be outlined in more detail later in this report.

Residents living in this centre received a very individualised service and were encouraged to be involved in both the running of the centre and their daily lives. In line with their wishes and preferences, residents were involved in laundry, cleaning, managing refuse, painting, gardening, going to the post office and other tasks of day to day living. Residents engaged in a variety of recreational activities. These included going for coffee, walks in local areas, visits to the barber, shopping for clothes and in-house activities like massage and decorating the house for Christmas. On the day of inspection staff supported two residents to go swimming. This was an activity that residents were keen to return to following the easing of COVID-19 related restrictions.

Residents' rights and independence were promoted. Residents were supported to have choice and control over the activities they participated in, including visits to family members. They were encouraged to prepare their own meals and pay for things themselves when out. Residents meetings were held monthly in the centre. It was a clear that the centre was operated in a manner that respected each resident's individual needs. The culture in place was one where the support and services provided were tailored to the residents, with one document outlining the importance of honouring one resident's diagnosed condition.

Contact with friends and family was very important to the residents in the centre and this was supported by the staff team. Relatives were welcome in the centre and staff also supported residents to visit their family homes regularly. The inability to visit relatives' homes at certain times during the COVID-19 pandemic had been very challenging for some residents. Although the staff team had supported residents to maintain contact by post, telephone and video calls, this was not a match for spending time with relatives. All four residents had spent time staying with family members in recent months and welcomed this return to their usual routines. Staff further supported the maintenance of these key relationships by helping residents to buy and wrap presents, and send cards for important events during the year.

The inspector reviewed the residents' assessments and personal plans. These were comprehensive and provided guidance on the support to be provided to residents. A multidisciplinary review of these plans had been held completed in the last 12 months, as is required by the regulations. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, weekly schedules, and daily support needs including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. There was evidence of regular review of these plans.

Residents' healthcare needs were well met in the centre. Where a healthcare need had been identified a corresponding healthcare plan was in place. It was noted that the provider had arranged for a registered nurse to review the healthcare plans in place for each resident. There was evidence of regular appointments with medical practitioners including specialist consultants as required. There was also evidence of input from allied health professionals such as speech and language therapists, psychologists and opticians. All residents who required one, had a recently reviewed feeding, eating, drinking and swallowing assessment and support plan. A summary profile had been developed for each resident to be brought with them should they require a hospital admission. There were two copies of this profile stored in the centre, one in each resident's file and another in an emergency folder. There were some inconsistencies between the two copies as they were reviewed at different times by different staff members. It was also identified that some key information on one resident's summary profile required an update. The system for reviewing and updating these duplicate documents required review.

Residents who required them had plans in place to guide staff on how best to support them with any behaviour challenges. These plans included proactive approaches to prevent or reduce the likelihood of an incident occurring, and also response plans to be implemented if required. These had been developed with the input of multidisciplinary professionals. Staff spoken with had a good awareness of these plans and were confident on how to implement them. There was only one restrictive practice in use in the centre. This intervention was used on an as needed basis. There was evidence that this was regularly reviewed and had been reduced in the last 12 months.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. In this centre, this planning process also incorporated healthcare related goals and other elements of the day-to-day support provided by staff. These goals were reviewed quarterly in line with provider's own policies and procedures. Due to the large number of goals documented for each resident, it was noted that not all personal development goals were reviewed each quarter. As a result, it was not always possible to see residents' progress in achieving their goals. For example, one resident had goals to attend a live traditional music session, go on a train journey and have a hot towel shave. In the two documented reviews completed since these goals were developed there was no reference to any of these goals.

The inspector reviewed the centre's risk register. This had been recently reviewed

and was regularly updated. There were some documentation issues noted whereby the scores on the overview sheet were not the same as those on the individual risk assessments, not all updates to the risk assessment were signed, and it was not always clear what control measures continued to be in place to mitigate against specific risks. It was identified that some risk assessments required review to ensure that the likelihood and impact ratings of the identified risks were accurate and reflective of the risk posed by identified hazards in the centre. For example the impact of residents choking was assessed as minor. There was evidence that risk assessments were updated regularly, including after adverse events.

Systems were in place and effective for the maintenance of the fire detection and alarm system and emergency lighting. Residents all had personal emergency evacuation plans (PEEPs) in place, and these had been reviewed recently. Regular fire drills were taking place in the centre with low evacuation times recorded. There was one exception to this whereby it took over six minutes for the residents to evacuate in night-time conditions. This drill was discussed with members of the management team who outlined the discussion and review that took place following this drill. It was planned to repeat another drill in this scenario. It was also noted that one designated fire exit led to a small, enclosed garden where it was not possible to access the assembly point. A review was therefore required to assess if this exit led to a place of safety, as is required by the regulations.

The inspector reviewed some of the systems in place regarding the prevention and control of healthcare associated infections, including COVID-19. Infection prevention and control (IPC) audits were completed monthly in the centre. IPC practices and standard precautions were observed on the day of inspection. Up-to-date guidance from the provider and public health was available to staff in an electronic format. There had been an outbreak of COVID-19 in the centre in recent months and the staff team had been successful in limiting this outbreak. Despite this, a clear contingency and isolation protocol was not documented in the centre.

Members of the management team had recently visited the centre to identify any areas where maintenance was required. A list had been developed and it was noted that some of the required works had already been completed. As outlined previously, the centre was observed to be clean on the day of inspection. However the surface of the kitchen counter was observed to be damaged. As a result it would not be possible to effectively clean this surface. This, and the associated IPC risk, had also been identified by management during their recent visit.

Regulation 10: Communication

Residents were supported at all times to communicate in line with their needs and wishes. Staff were knowledgeable about each resident's individual communication supports, and were observed using augmentative and alternative communication approaches to aid residents' understanding.

Judgment: Compliant

Regulation 11: Visits

Residents were free to receive visitors if they wished and communal facilities were available to facilitate this.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. They were known in their local community and regularly spent time there. Each resident attended day services.

Judgment: Compliant

Regulation 17: Premises

The designated centre was clean and decorated in homely manner. The design and layout met the current needs of the residents. The provider had highlighted that this would be kept under review as the residents grew older. The centre was generally in a good state of repair however painting was required in some areas.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were involved in meal preparation in line with their wishes. Food provided was wholesome, nutritious and popular with the residents. Staff were aware of residents' mealtime support needs.

Judgment: Compliant

Regulation 26: Risk management procedures

The centre's risk register was well maintained. The scoring of some risk assessments required review to ensure that they were reflective of the risk posed by identified hazards in the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19. All staff had recently completed training in infection prevention and control and hand hygiene. A COVID-19 contingency and isolation plan, reflective of, and specific to, this centre was required. The centre was observed to be clean. However the kitchen counter was damaged. It would not be possible to effectively clean this surface.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety systems in place in this designated centre included a fire alarm, emergency lighting and fire fighting equipment. Fire drills were taking place regularly. Training records reviewed indicated that all staff had received fire safety training. One designated fire exit required review to ensure that it led to a safe location.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs of each resident had been completed. Each resident had a comprehensive personal plan that had been subject to a multidisciplinary review. Improvements were required in the review of residents' personal development goals and to ensure that all documents were updated following changes to key information.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff had sufficient knowledge and skills to support residents whose behaviour at times was challenging. Any restrictive procedures in place were regularly reviewed to ensure the least restrictive procedure was used.

Judgment: Compliant

Regulation 8: Protection

There were no safeguarding concerns in the centre at the time of this inspection. All staff had received appropriate training in relation to safeguarding residents and the prevention, detection, and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was operated in a manner that respected each resident's rights. Each resident received a service tailored to their individual needs, preferences and requests. Residents were encouraged and supported to exercise choice and control in their daily lives.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No.5 Stonecrop OSV-0005144

Inspection ID: MON-0031499

Date of inspection: 17/08/2022

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider will arrange that iaudits conducted are completed in full or at the frequency identified in our policies and procedures. We will review elements of our document management systems in the centre to ensure that these are kept updated.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The registered provider has ensured that the statement of purpose has been reviewed ensuring that all information is up to date date and accurate including updated information on the residents' return to attending day services. The most recent version of the statement of purpose was placed in the centre on the day of the inspection, replacing an earlier version. The Provider will ensure a system is in place to ensure future updates are available in the Centre on a timely basis.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The Provider will ensure that notifications are uploading to the correct Designated Centre on the Authority's notification portal and that if an error is made the incorrect notification is cancelled and re-submitted for the correct Centre. In this case the email notification to Authority within the notification period but uploaded to the incorrect Centre. The error was notified to the Authority on that date and the incorrect notification cancelled. The notification was resubmitted on 26/08/22.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The registered Provider will review the risk assessments in the Centre to ensure that they are reflective of the risk posed by identified hazards in the centre. The rating of risks will also be reviewed and the Provider will ensure that these ratings are concistently recorded on the assessment and the summary of risks in the Centre.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The registred provider will ensure that all Provider ICP systems are in place in the Centre. The Centres Contingency Plan including the isolation protocol will be updated. The Provider will ensure that the kitchen counter is repaired.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider will review the fire exit that currently leads to the rear garden which is an enclosed area to ensure it meets safety standards.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The person in charge will ensure that the residents' personal development goals are in place and reviewed on a regular basis. The Person in Charge will also ensure that there is little or no duplicaiton of records and that documents are updated following changes to key information.	

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 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.	Substantially Compliant	Yellow	11/09/2022
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	31/10/2022
Regulation 27	The registered provider shall ensure that residents who may	Substantially Compliant	Yellow	31/12/2022

	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.			
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.	Substantially Compliant	Yellow	16/09/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	17/08/2022
Regulation 03(3)	The registered provider shall make a copy of the statement of purpose available to residents and their representatives.	Substantially Compliant	Yellow	17/08/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each	Not Compliant	Orange	26/08/2022

	quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/12/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/12/2022