Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	National Association of Housing for Visually Impaired
Name of provider:	National Association of Housing for Visually Impaired
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	12 March 2019
Centre ID:	OSV-0001938
Fieldwork ID:	MON-0024920

About the designated centre

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

This residential service is for vision impaired adults, both male and female, with additional disabilities. The centre can cater for 16 residents over the age of 18 years. The centre is staffed with two social care workers, and 20 care assistants along with the person in charge and service manager. The centre comprises of four houses which are close to local amenities such as shops, train stations, bus routes and churches. Day services are not provided. Residential care is provided across 24 hours with sleep over staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
12 March 2019	09:30hrs to 17:30hrs	Maureen Burns Rees	Lead

Views of people who use the service

As part of the inspection, the inspector met with eight of the 16 residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. One of these residents was unable to tell the inspector their views of the service but the inspector observed warm interactions between the resident and the staff caring for them. Other residents spoken with, told the inspectors that they enjoyed living in the centre and of the many activities they enjoyed engaging in within the centre and in the local community. Overall, residents were supported to choose goals that were meaningful to them and residents were actively involved in the running of their home. Staff were observed to be kind, caring and respectful with residents. Residents spoken with, reported that staff were very good to them and that they enjoyed spending time with staff.

There was some evidence that residents and their family representatives were consulted with, and communicated with, about decisions regarding their care and the running of the centre. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspectors did not have an opportunity to meet with the relatives of any of the residents on this inspection but staff reported that they were happy with the care their loved ones were receiving.

Capacity and capability

Management systems and processes to promote the service provided to be safe, consistent and appropriate to the residents' needs had improved since the last inspection. However, there remained some areas for improvements to ensure that the service provided was safe and appropriate to meet each of the resident's needs. In addition, the long term plans for the governance and management of the centre had not yet been confirmed.

At the time of the last inspection, there were ineffective governance and management systems in place to oversee the care and support being delivered. In addition, accountability and responsibility arrangements for the provider and management team were not clear. Since that inspection, a clearly defined management structure has been put in place which identifies lines of accountability and responsibility.

The provider commissioned an external company, with reported expertise within the area, to support the provider and oversee a reconfiguration of the service with the aim of bringing the centre into compliance with the regulations. A formal

memorandum of understanding was put in place to allow provisions for the external company to manage and govern all aspects of service delivery and human resource management in the centre. This included the appointment of an operations manager and service manager from the external company in August 2018. The executive director, also employed by the external company has joined the board of directors for this centre and is the nominated provider representative. The person in charge reports to the operations manager who in turn reports to the provider representative. The external company provides training, oversight, person centred planning processes and direct management of the centre.

The memorandum of understanding is due to expire in August 2019. However, arrangements for the governance, operation and management of the centre after this date have not yet been confirmed and a succession plan, at the time of the inspection had not been developed. The provider had not demonstrated how the capacity, competencies and capabilities of the board and management team had been strengthened in anticipation of the expected termination of the memorandum of understanding which is due to expire August 2019.

The centre was managed by a suitably qualified, skilled and experienced person who had a good knowledge of the needs of each of the residents. An interim person in charge had been appointed whilst the previous person in charge was on a period of extended leave. The interim person in charge was in a full time position and was not responsible for any other centre. She held an honours degree in social care and a masters in social care management. She had more than five years management experience. Staff members spoken with told the inspector that she supported them in their role. There was evidence of regular formal and informal contact between the interim person in charge and the management team. Since the last inspection, an additional service manager and two shift leaders had been appointed to support the person in charge.

The first six monthly unannounced visits to assess the quality and safety of the service had been completed in November 2018. There was evidence that actions were taken to address issues identified on these visits. However, the provider had not yet completed an annual review as per the requirements of the regulations. Since the last inspection a number of monitoring systems had been put in place. These included a monthly quality and monitoring monthly report which was compiled by the person in charge and submitted to the operations manager. In addition a monthly report was compiled on a consolidated action plan, based on non-compliances identified in other inspection reports and audits. A number of audits had also been commenced since the last inspection and there was evidence that actions were taken to address issues identified. However, the inspector found that a small number of audits undertaken were not fully effective and had failed to identify issues detected on this inspection. For example an audit of policies required under Schedule 5 of the regulations, failed to identify a policy which was not in place and that a further policy did not meet the requirements of the regulations. There was evidence that the operations manager completed a formal safety walk around on a monthly basis.

Since the last inspection, information communication technology had been

introduced across the centre which included, a number of desktop computers and lap tops. This was welcomed by staff and residents.

The staff team were found to be appropriately skilled, qualified and experienced to meet the assessed needs of the residents. There was an actual and planned staff roster. The full complement of staff as stated in the providers statement of purpose was in place. However, a formal assessment of staff dependency levels had recently been completed and identified that the current staffing levels were not sufficient to meet the needs of some of the residents.

Training had been provided to staff to support them in their role and to improve outcomes for residents. There was a staff training and development policy. A training programme was in place which was coordinated by the provider's education coordinator. Training records available on the day of inspection indicated that a small number of staff were overdue to attend some mandatory training. Specific training to meet residents' assessed needs had been provided for staff. There were no volunteers working in the centre at the time of inspection.

Staff supervision arrangements were in place. However, staff supervision was not being undertaken in line with the frequency proposed in the provider's policy.

Records were maintained in the centre as required by the regulations. However, a number of policies required as per Schedule 5 of the regulations were not in place. These included a policy on communication with residents and a policy on the provision of information for residents. Hard copies of policies in place were maintained in the centre. However, there was a limited index system for accessing policies which meant that it could be difficult for staff to locate specific polices as required.

Regulation 14: Persons in charge

The interim person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre.

Judgment: Compliant

Regulation 15: Staffing

The staff team in place were considered to have the required skills and competencies to meet the needs of the residents living in the centre. However, formal staff dependency levels had recently been completed and identified that the current staffing levels were not sufficient to meet the needs of some of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. However, records available on the day of inspection indicated that a small number of staff were overdue to attend some mandatory training. Staff supervision arrangements were in place. However, supervision was not being undertaken in line with the frequency proposed in the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a quality and safe service. However, an annual review of the quality and safety of care in the centre as required by the regulations had not yet been completed. A small number of audits undertaken were not fully effective and had failed to identify issues detected on this inspection.

A formal memorandum of understanding had been put in place to provide for an external company to manage and govern all aspects of service delivery and human resource management in the centre. The memorandum of understanding is due to expire in August 2019. However, arrangements for the governance, operation and management of the centre after this date had not yet been confirmed.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

A sample of residents' written agreements were reviewed and found to outline the services to be provided and all fees payable as per the requirement of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre were maintained and where required, notified to the Chief Inspector. However, it was identified that an incident had not been reported within the timelines required in the regulations.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A small number of policies required as per schedule 5 of the regulations were not in place. These included a policy on communication with residents and a policy on the provision of information for residents. Hard copies of policies in place were maintained in the centre. However, there was a limited index system for accessing policies which meant that it could be difficult for staff to locate specific polices as required.

Judgment: Not compliant

Quality and safety

Overall, the residents living in the centre received care and support which was of a good quality and person centred. However, improvements were required in relation to the arrangements for medication management, risk management, behavioural support and person centred planning.

The residents' well-being and welfare was maintained by a good standard of care and support. The centre was in the process of developing new plans for each of the residents which were based on an assessments of the resident's needs. However, there was limited evidence of the involvement of resident's families in developing these plans. The personal plans in use at the time of inspection had not been reviewed for an extended period and did not address some residents' health, social and personal needs and the support required to maximise their personal development. It was noted that goals set for some residents were not specific or measurable. There was evidence that regular meetings took place with individual residents and their key workers.

The residents were each supported to engage in meaningful activities in the centre and within the community. A number of the residents were engaged in formal day programmes and courses. Other residents had part-time jobs in local businesses, on either a voluntary or paid basis. Examples of other activities that residents engaged in included, swimming, horticulture and gardening, horse riding, a walking club, gym fitness classes, music classes, choir group, social club, cinema and meals out. A large number of the residents enjoyed playing and listening to music. On the day of

inspection, a number of residents displayed for the inspector their great talent at playing the keyboard and guitar.

Arrangement to meet residents' healthcare needs had improved. At the time of the last inspection, residents had not been appropriately referred to allied health care professional where needs were apparent, and records were not well maintained. Since the last inspection, health action plans had been put in place for residents identified to require same. Access to allied health professionals had been sourced through an external company and assessments completed for a number of residents. Reports for these assessments had not yet been provided. Specific health plans were in place for residents who required same. Each of the residents had their own general practitioner (GP).

There was evidence that residents were offered a variety of meals, drinks and snacks. Meal planners were in place which had been agreed in advance by residents. The inspector observed meal time in one of the units to be a social occasion with residents being supported in line with their assessed needs and preferences in an appropriate manner. Snacks and drinks were available for residents outside of mealtimes.

The design and layout of the centre was fit for purpose and reflected the layout as described in the centre's statement of purpose. The centre had a homely feel and was well maintained. The centre comprised of four separate houses but two sets of the house where located beside each other with interconnecting back gardens. Each of the houses had beautifully manicured back gardens which were maintained with the assistance of a number of the residents.

There were systems in place to ensure the safe management and administration of medications. However, on review of a sample of prescription and administrating records, the following issues were identified: maximum dose for PRN or as required medications was not recorded on some prescription sheets, a number of over the counter medications were not prescribed or recorded for some residents, allergy status not stated on prescription sheets and frequency for some short term or PRN or as required medications was not stated. It was observed that a medication which had been discontinued on a residents prescription kardex for an extended period was still being stored in the medication cupboard for one resident. Assessments had only been completed for a small number of the residents to assess the ability of individual residents to self manage and administer medications. All staff had received appropriate training in the safe administration of medications with the exception of one staff member who was on extended leave. Systems to review and monitor safe medication management practices had been introduced since the last inspection with the introduction of regular audits by the service manager. These audits identified a number of the issues noted on this inspection, and action plans had been put in place. An audit had also been completed by the pharmacist. Counts of all medications were undertaken on a weekly basis.

There were measures in place to keep residents safe and to protect them from harm. There was a safeguarding policy in place. Staff members spoken with were knowledgeable about the signs of abuse and what they would do in the event of an

allegation, suspicion or disclosure of abuse. There had been no incidents or suspicion of abuse in the previous 12 month period. All staff had attended appropriate safeguarding training. A residents' meeting was held on a weekly basis this covered rights and safeguarding. Intimate care plans were in place for residents who required support in this area and these were found to contain sufficient detail to guide staff in meeting the individual resident's intimate care needs.

Residents were provided with emotional and behavioural support. However, behaviour support plans had not yet been put in place for three residents who were identified to require same. This meant that staff did not have specific guidance to support residents to manage their behaviour and or to respond to individual residents behaviour in a consistent manner. The behaviour of one resident was identified to have a negative impact on other residents but staff had put measures in place to support the residents involved. Since the last inspection a new recognised model for positive behaviour support had been introduced into the centre. Training had been provided for the majority of staff on this new model but there were two staff members who had not yet received training.

Overall, the health and safety of residents, visitors and staff were promoted and protected. However, some individual risk assessments for residents had not been reviewed for an extended period. There was a risk management policy in place. However, it did not meet all of the requirements of the regulations. For example, it did not clearly state the measures and actions in place for a number of specified risks, including accidental injury to residents, visitors or staff, aggression and violence, and self harm. In additions the arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents were not clearly stated. There was a safety statement, with written risk assessments pertaining to the environment and work practices which had recently been revised. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were a very low number of incidents and accidents in the centre but there were arrangements in place for investigating and learning from incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences. The inspector reviewed a sample of all incidents and accidents reported which also recorded actions taken.

Regulation 18: Food and nutrition

Residents were encouraged to eat a varied and nutritious diet.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall, the health and safety of residents, visitors and staff were promoted and protected. However, some individual risk assessments for residents had not been reviewed for an extended period. There was a risk management policy in place. However, it did not meet all of the requirements of the regulations. For example, it did not clearly state the measures and actions in place for a number of specified risks, including accidental injury to residents, visitors or staff, aggression and violence, and self harm. In additions the arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents were not clearly stated.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

A number of prescribing and recording issues were identified which included the following: the maximum dose for PRN or as required medications was not recorded on some prescription sheets, a number of over the counter medications were not prescribed or recorded for some residents, allergy status was not stated on prescription sheets and frequency for some short term, PRN or as required medications was not stated.

Assessments had only been completed for a small number of the residents to assess the ability of individual residents to self manage and administer medications.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The centre was in the process of developing new plans for each of the residents which were based on an assessments of the resident's needs. However, there was limited evidence of the involvement of residents' families in developing these plans. The personal plans in use at the time of inspection had not been reviewed for an extended period and did not address some residents' health, social and personal needs and the support required to maximise their personal development. It was noted that goals set for some residents were not specific or measurable.

Judgment: Not compliant

Regulation 6: Health care

Residents were being supported to enjoy the best possible health.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with emotional and behavioural support. However, behaviour support plans had not yet been put in place for three residents who were identified to require same. Training had yet to be provided for two staff members on a new recognised model for positive behaviour support which had been introduced into the centre since the last inspection.

Judgment: Not compliant

Regulation 8: Protection

There were measures in place to keep residents safe and to protect them from harm.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for National Association of Housing for Visually Impaired OSV-0001938

Inspection ID: MON-0024920

Date of inspection: 12/03/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The person in charge had completed dependency assessments prior to the date of inspection. These were forwarded to the relevant Disability Services Manager (CHO9) on 13.02.19 identifying the need for increased funding. • Discussions are ongoing with CHO9 to agree the additional funding required in order to provide the appropriate staffing levels. • A pool of relief staff was created to provide additional support, completed June 2018. • A recruitment process was initiated in April 2019 and has been completed.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The person in charge has completed and reviewed training metrics which highlights training refresher dates. • All staff will have completed Manual Handling training by 05.05.19. • All staff will have completed Safe Administration of Medication training by 17.04.19. • All staff will have completed First Aid training by 26.04.19. • All staff will have completed Positive Behaviour Support training by 23.04.19. • All staff will have completed Fire Safety training by 30.04.19. • A schedule of supervision has been developed in line with policy and two additional members of the management team are now trained to deliver Person Centred Supervision.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• An Annual Audit is scheduled and will be completed by 30.04.19.
• NAHVI's policies on communication with residents and the provision of information for residents have been deemed compliant in "sister" services, however, a review of all Schedule 5 Policies will be completed by 31.05.19.
• A review of auditing systems has been undertaken and will be completed by 31.05.19. An audit schedule is implemented which ranges from daily on site audits to announced and unannounced monthly monitoring visits completed by the Operations Manager.
• Arrangements for the governance, operation and management of the centre post-August 2019 (the date the memorandum of understanding between NAHVI and the external company expires) will be addressed as a standing agenda item at future Board of Directors meetings and appropriate arrangements will be put in place by July 2019.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• A copy of notifiable incidents and escalation procedures have been made available to all staff via noticeboards etc.
• An on call system is now in place with contacts of senior staff.
• Incident reporting arrangements were discussed with all staff at a meeting on 21.03.19.
• Ongoing communication with the inspector is maintained.
• All staff are safeguarding trained.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies

and procedures:
• NAHVI's policies on communication with residents and the provision of information for residents have been deemed compliant in "sister" services, however, a review of all Schedule 5 Policies to reflect the inspector's comments / meet the requirements of the regulations will be completed by 31.05.19.
• The Safeguarding Policy has been amended to include the Service Managers' names and contact details.
• A more accessible index has been created, separating all Schedule 5 policies from other organisational policies.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The individual risk assessments which were overdue for review will be reviewed by 30.06.19.
• NAHVI's risk management policies have been deemed compliant in "sister" services, however, a review of all Schedule 5 Policies to reflect the inspector's comments / meet the requirements of the regulations will be completed by 31.05.19.
• A user-friendly risk escalation process is designed and will be implemented by 31.05.19.
• A serious incidents / adverse events protocol will be designed and implemented by 31.05.19.
• Risk is now a standing agenda item at all team meetings.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• In collaboration with the pharmacist, a review of all MAR / Prescription and all outstanding areas of concern have been rectified as per policy and regulation. This was completed on 01.04.19.
• A review of all PRN prescriptions and protocols will be completed by 30.04.19.
• A Medication Competency Assessment for all staff has been introduced and will be completed with management by 30.04.19.
• Self-administration assessments will be completed for all residents by 30.04.19, to include risk update for Health Care Plans.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• Person Centred Portfolios are being developed for each resident in line with regulatory guidelines and with an individualised focus. These will be in place by 30.04.19.

• All annual reviews are scheduled to include family, multi-disciplinary professionals and people who are involved with, or important to, the resident (with the resident's consent). These will be completed by 30.06.19.

• The person in charge attended Person Centred Thinking training on 9/10.04.19 and is scheduled to attend Adult Social Care Outcomes Tool (ASCOT) and Active Support training 31.05.19.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• All behaviour support assessments have been completed by a Positive Behaviour Support Specialist. The three outstanding reports will be in place by 30.04.19, however, interim plans are in place for these individuals.

• All staff will have completed positive behaviour support training by 23.04.18.

• A Positive Behaviour Support Specialist is available to provide support and coaching to staff as and when 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	30/04/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	06/05/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately	Substantially Compliant	Yellow	31/05/2019

	supervised.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	18/07/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/04/2019
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	30/04/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	31/05/2019

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	30/04/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Not Compliant	Orange	30/04/2019
Regulation	The person in	Substantially	Yellow	16/04/2019

31(1)(f)	charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Compliant		
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Yellow	31/05/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	30/04/2019

Regulation 05(6)(a)	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 be multidisciplinary.	Not Compliant	Yellow	30/04/2019
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.	Not Compliant	Orange	30/06/2019
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	23/04/2019