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:	Castlefield Group - Community Residential Service
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 15
Type of inspection:	Short Notice Announced
Date of inspection:	18 September 2020
Centre ID:	OSV-0005237
Fieldwork ID:	MON-0025947

About the designated centre

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

Castlefield group is a community residential service providing adult residential accommodation for ten ladies and five gentlemen with an intellectual disability across three residential locations. The houses are close to a variety of local amenities such as hairdressers, beauticians, pharmacy, shops, pubs, churches and parks. The first location currently provides accommodation for four ladies, the second for five gentlemen and the third for six ladies. The first location is a semi-detached house on a small cul-de-sac. It comprises of five single occupancy bedrooms one of which is used as a staff office and sleepover room. There is a kitchen/dining room, sitting room, downstairs toilet and a main bathroom upstairs. The second house has five bedrooms and two residents share a bedroom. There is a kitchen/dining room, sitting room, downstairs toilet and a main bathroom upstairs. The third house is a six bedroomed semi-detached house in a cul-de-sac. There is a kitchen/dining room, sitting room, downstairs toilet and a main bathroom upstairs. All residents have their own bedrooms in this house. The staff team provides low support for residents, with two houses with one sleepover staff, and the other house with an extra support staff during the day.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 18 September 2020	10:30hrs to 16:15hrs	Thomas Hogan	Lead
Friday 18 September 2020	10:30hrs to 16:15hrs	Marie Byrne	Support

What residents told us and what inspectors observed

Residents spoken with during the course of the inspection described the impact of restrictions in line with public health advice in line with the COVID-19 pandemic for them. A number of residents described the importance of going to work or attending day service, and told inspectors about how much they were missing them. Some residents told the inspectors they understood why they could not attend at present in line with public health advice. They described things that were important to them including relationships with friends and families. They shared some of their goals and achievements with inspectors, including travelling to work independently, seeking employment, accessing and attending events in their local community, using their tablet computers to order items online, voting regularly, and attending sporting events.

The inspector spoke with two residents who were currently sharing a bedroom. They both voiced their dissatisfaction with this arrangement and described the impact this was having for them. They described having to ask each other to leave the room when they were getting dressed and how they were disturbing each others sleep at night. There was an open complaint relating to residents sharing their bedroom at the last inspection, and this complaint remained open at the time of this inspection. One residents described their frustrations in relation to the unsatisfactory and delayed response to the complaint and described how they felt that no one was listening to them. Residents had been supported to access advocacy services, and one resident was in regular contact with this service.

Residents who spoke with the inspector said they were aware on the complaints process and told inspectors who they would speak to if they had any concerns relating to their care and support in the centre. A number of residents were very complimentary towards the staff team. They described how well supported they felt and told the inspectors that they were happy, felt safe and liked living in the centre.

The inspectors observed kind and caring interactions between residents and staff when they visited the houses, and residents appeared comfortable and relaxed.

Capacity and capability

There were 15 residents living in the designated centre on the day of the inspection. The designated centre is comprised of three houses with six residents living in one of the houses and five residents in each of the other two house. Due to COVID-19 related restrictions, the inspectors visited one house each meaning in total that two of the three houses which make up this centre were visited as part of this inspection. The inspectors met with nine residents, three staff members and the

person in charge during the course of the inspection.

Overall, the inspectors found that while the care and support being provided to residents was safe and person-centred, considerable improvements were required across a significant number of regulations in order for this centre to come into compliance with the regulations. There were a number of actions which the registered provider had not completed from the time of the previous inspection including the installation of fire containment measures in one unit and resolving the dissatisfaction of residents with the shared bedroom arrangement in another unit.

While reviewing the arrangements in place for the governance and management of the centre, the inspectors found that there was an absence of effective management systems in place in the centre to ensure appropriate oversight of the care and support being delivered. For example, the person in charge or registered provider had not recently assessed staff training compliance with their own policy requirements and while an audit in December 2019 had found deficits, these had not been addressed. Another example was found in the area of risk management. A number of risks which were presenting and leading to the occurrence of incidents in the centre had not been appropriately identified, assessed and controlled. The inspectors also found that the centre was not appropriately resourced. This specifically related to the number of staff employed in the centre and how the staffing ratio did not meet the needs of residents. The inspectors found, however, that there was a clearly defined management structure in place and the person in charge had a vision and a drive to address the non-compliances which were identified with the Regulations.

The inspectors reviewed the centre's complaints records and found that the registered provider had not ensured that the practice outlined in the organisation's policy for managing complaints was implemented in practice. For example, a number of complaints which reflected the dissatisfaction of residents who had to share a bedroom were made and some predated the previous inspection of this centre. There was an absence of evidence to demonstrate that the registered provider had completed required actions under the individual stages of the complaints process outlined in their policy document. This included the completion of a formal review or investigation into the matter. The inspectors found that basic systems were not in place in the centre such as a the maintenance of a central complaints register and as a result there was ambiguity amongst the management team as to the current statues of the complaints made.

Improvements had been made in relation to the continuity of care and support for residents since the last inspection. The provider had recruited to fill a number of vacancies. However, there were not adequate numbers of staff to meet the number and needs of residents in the centre. The provider had recognised the changing needs of a number of residents in one of the houses in the centre and recently approved an increase in staffing support in the centre. However, this increase was not sufficient to meet the assessed needs of residents as two residents were now more dependent on staff for support with personal care and to maintain their activities in the community. On occasions, a number of residents in this house do not wish to engage in some activities and as there is only one staff on duty, this was

resulting in limited access for other residents access to activities. In addition, a safeguarding plan was in place which outlined the requirement for additional supports at key times.

During the inspection, the inspectors observed staff engaging with residents in a supportive and respectful manner. Residents appeared comfortable in the presence of staff and with the levels of support offered to them. Staff who spoke with the inspectors were found to be knowledgeable in relation to residents' specific care and support needs and motivated to ensure residents were happy, safe, setting and achieving their goals. Staff were particularly motivated to encourage residents to maintain and where necessary develop their skills in relation to their independence.

The provider had recently reviewed their staff training policy and included a section relating to changes in training in line with COVID-19. In this updated policy the provider referred to the use of a risk based approach to staff's training needs, with any training identified as essential to deal with presenting risk to be prioritised. A high number of staff had not completed a number of refresher training courses which were identified by the organisation's policy as mandatory. For example, 22% of staff required manual handing refresher training, 77% required fire safety awareness refresher training, 22% required safeguarding refresher training, 88% required safe administration of medication refresher training, and 100% of staff required food safety refresher training.

In line with the findings of the last inspection, staff supervision had not been formalised in the centre. There was no documentary evidence of meetings between the person in charge and members of the staff team. Staff who spoke with the inspector stated they were well supported and being encouraged by the person in charge to carry out their roles and responsibilities, to the best of their abilities. They also stated that they aware of who to escalate any concerns, relating to the quality and safety of care for residents to.

Regulation 15: Staffing

There were planned and actual rosters in place, and from the sample reviewed, there was evidence that residents were in receipt of continuity of care, with a small number of shifts being covered by regular relief staff.

There were not a sufficient number of staff to meet the number and needs of residents in the centre. This related to one of the houses in line with the changing needs of residents. The provider had recognised these changing needs and recently approved an increase in staffing supports. However, staffing supports remained insufficient at times. For example, at weekends additional staffing support was required to meet residents' care and support needs.

Judgment: Not compliant

Regulation 16: Training and staff development

A number of staff had not completed refresher training listed as mandatory in the organisation's policy. For example;

- one staff had not completed manual handling refresher training,

- two staff had not completed fire safety awareness refresher training

- one staff had not completed safeguarding refresher training

- seven staff had not completed safe administration of medication refresher training

- all staff in the centre required refresher food safety training.

There was no formal supervision process in place. There was no documentary evidence presented to show regular meetings between the person in charge and the staff team. Despite this, staff reported that they were well supported and aware of their roles and responsibilities in relation to the quality and safety of care and support for residents.

Judgment: Not compliant

Regulation 23: Governance and management

There was an absence of management systems to ensure that care and support being provided was satisfactory, to ensure that there was appropriate oversight in the centre, and to ensure that actions and conditions of registration where implemented in practice. In addition, the inspectors found that the centre was not appropriately resourced.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed incident and accident records and found that notification to the Office of the Chief Inspector were made as required by the Regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Appropriate systems were not in place in the centre for the management of complaints made. In addition, the inspectors found that the management of ongoing complaints relating to the sharing of bedrooms by residents was not in line with the requirements set out in the organisation's policy.

Judgment: Not compliant

Quality and safety

The inspectors found that the premises of the centre were clean, well presented and homely in nature. However, due to the ongoing concern relating to the sharing of a bedroom by two residents, the inspectors found that the centre was not designed or laid out to meet the number and needs of the residents availing of its services. The centre lacked adequate private accommodation for residents and while residents, staff members and independent services had advocated on the behalf of the individuals involved over a prolonged period of time, the matter had not been successfully resolved. Residents involved informed the inspectors of the impact that these arrangements had on their lives which included waking from their sleep at night due to another resident using the bathroom and the lack privacy when dressing.

While reviewing the management of risk in the centre, the inspectors found that there was a policy in place which met the requirements outlined by the Regulations. There were individual risk registers in each of the three units of the centre and these were reviewed by the inspectors. The absence of an overall centre level risk register was found to result in the limited oversight of risk. For example, a review of incident and accident records found high levels of medication errors in the centre, however, the risk registers in each unit risk rated "administering medications" risks as "low". In addition, the associated risk assessments were not comprehensive in nature and it was not clear in any of the three cases what control measures were in place to manage this concerning risk. Compounding this matter was the fact that only two of the nine staff members working in the centre had completed training or refresher training in the area of safe administration of medication.

Accessible information was available to residents in relation to public health measures during the pandemic. For example, there were leaflets relating to COVID-19 testing, personal protective equipment (PPE), hand washing, residents' rights, accessing advocacy services during the pandemic, and a guide to safe shopping during the pandemic. The provider had developed policies, procedures and guidelines for use during the pandemic. They had also updated existing polices, procedures and guidelines to include information relating to COVID-19. Staff had access to some stocks of personal protective equipment (PPE) in the centre and

there were systems in place for stock control and ordering. There was a COVID-19 information folder available in the centre, which was updated with relevant policies, procedures, guidance and correspondence. These included documents such as a COVID-19 response plan, a business continuity plan, cleaning and disinfection guidelines, visiting procedures and guidelines, and a COVID-19 local induction checklist for each house. Each resident had individual risk assessments developed and reviewed relating to areas such as, contracting COVID-19, community access, attending appointments during the pandemic, and visiting family and friends.

The inspectors reviewed fire safety precautions in the centre and found that fire drills were being completed on a regular basis and records of these drills demonstrated that residents could evacuate in a safe and timely manner. Records reviewed confirmed that the fire alarm and detection system and emergency lighting was serviced and maintained on a regular basis. While there were risk assessments completed for each resident regarding the evacuation of the centre in the event of a fire, there were no personal emergency evacuation plans in place. Fire containment measures had been installed in two of the three units of the centre in the time since the previous inspection. While the provider had commenced the instillation of fire containment measures in the third unit of the centre, this work had not been completed.

From speaking with residents and staff, and from reviewing documentation in the centre, it was evident that there was a strong culture of person-centredness in the designated centre. Residents were being support to develop and achieve their goals. These goals were regularly being evaluated and updated and leading to the development of new and innovative goals. Residents were being supported to develop and maintain friendships and to have meaningful experiences including holding valued social roles. Each resident had a personal plan which outlined the supports they needed to maximise their personal development and to ensure they had opportunities to have new experiences. The inspectors found that safe care was being delivered for residents and that staff were very familiar with residents likes, dislikes, preferences and care and support needs. However, the inspectors found that some residents' assessments and care plans required review to ensure they were consistent and reflective of residents' care and support needs. The inspectors found that these gaps in documentation were not leading to a high risk for residents.

Overall, residents were being supported to enjoy best possible health. However, care plans were in place for some healthcare needs, which had not been identified in their assessment of need. Residents were supported to access allied health professionals in line with their assessed needs. A number of residents' assessments required review to ensure they were accurate and reflective of residents' current assessed needs. In a number of residents' personal plans reviewed there was no documentary evidence to demonstrate how they were being supported to make decisions in relation to accessing national health screening programmes. The business continuity plan for the organisation outlined how residents could continue to be supported to access allied health professionals during the pandemic.

The inspectors reviewed the arrangements in place to protect residents from experiencing abuse. Staff members spoken with were knowledgeable of the different types of abuse and the actions required if safeguarding concerns were identified or reported. A sample of safeguarding plans were reviewed and were found to appropriately support residents. The inspectors spoke to a number of residents who all stated when asked that they felt safe living in the centre and knew how to report any concerns that they may have.

Residents' meetings were occurring regularly and agenda items were varied and included discussions relating to the day-to-day running of the centre. There was evidence of communication with residents to keep them informed during the pandemic. There was information available for residents in relation to advocacy services and one resident described their experience of accessing the support of an independent advocate. Residents were being supported to develop their goals and to make decisions relating to their care and support. Through speaking with residents, staff, and reviewing documentation in the centre, it was evident that they were being actively encouraged to exercise choice and control in their daily lives. However, due to the fact that two residents were sharing their bedroom, the provider was not ensuring that each residents' privacy and dignity was maintained in relation to their living space and intimate and personal care. Both residents' voiced that they would either like their own bedroom or to move to another house.

Regulation 17: Premises

The design and layout of the premises of one unit of the centre was found not to meet the number and needs of the residents who were availing of its services. There was a lack of private accommodation to meet the needs of residents and despite efforts by residents, staff members and independent advocacy services over a prolonged period of time, the matter had not resolved.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was an absence of appropriate systems for the identification, assessment and management of risk in the centre.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had some systems in place, including policies and procedures, to ensure residents who may be at risk of healthcare-associated infection were protected. These had been adapted and updated them during COVID-19 pandemic.

There were cleaning schedules in place which had been adapted in line with COVID-19. This included regular touch point cleaning a number of times daily.

Judgment: Compliant

Regulation 28: Fire precautions

Fire containment measures were not in place some areas of one unit of the centre which was found to be a breach of a condition of registration. In addition, individual personal emergency evacuation plans were not in place for residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need and personal plan in place. Overall, residents assessments clearly recognised and identified their health, personal and social care needs. However, a number required review to ensure they were reflective of residents' care and support needs. The inspectors found care plans in place for a number of residents for needs which had not been identified through a formal assessment of needs process. As a result the assessments of needs on file were not reflective of residents needs.

A number of personal plans required review to reflect changes in relation to residents' assessed needs. The inspectors found that staff were familiar with residents needs and that gaps in documentation were not leading to high risks for residents.

Judgment: Not compliant

Regulation 6: Health care

Overall, residents were supported to enjoy the best possible health. Residents' healthcare needs were assessed and care interventions were developed as required.

However, a number of residents' assessments and care interventions required review to ensure they were consistent and reflective of residents' current needs.

These gaps in documentation were not found to be contributing to a significant risk for residents but required review to ensure they were accurate.

Judgment: Substantially compliant

Regulation 8: Protection

The inspectors found that the registered provider had taken appropriate actions to protect residents from experiencing abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' meetings were occurring regularly in the centre. There was evidence that residents were participating in the day-to-day management of the centre.

Information relating to the availability of advocacy services was available for residents.

However, due to the fact that two residents were sharing their bedroom, the provider was not ensuring that their privacy and dignity was being respected at all times. Both residents voiced to the inspectors that they were not happy to share their bedroom and that they were not happy with how long it was taking to resolve this situation.

Judgment: Not 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	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Castlefield Group - Community Residential Service OSV-0005237

Inspection ID: MON-0025947

Date of inspection: 18/09/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Provider has approved an additional 35 hours support each week for one house in the designated centre to meet the assessed needs of the residents. This staff is now in place.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff are completing all on line mandatory training including safeguarding, manual handling, fire safety by 30th Nov 2020. All staff will complete on line medication refresher training on the 27th and 28th October 2020. All staff will complete food safety training by 30 December 2020. The PIC will undertake supervision training by 30th December 2020	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider, the PPIM and the PIC will review all oversight processes in place in the designated centre to include centre risk register, centre complaints register and centre training records and planner. The PIC will complete supervision training and will commence formal supervision training at the designated centre. The provider has increased the staffing in the designated centre to meet the assessed needs of the residents.

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Provider is dealing with complaints in line with the organizational policy. A stage 2 folder is in place with updated actions related to the complaint. Residents have been written to by the Provider updating them in relation to their complaints. The Provider has a clear timeline in which to resolve the open complaints.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Provider has purchased a house and following planning, tendering, renovations and registration with HIQA each resident in the designated centre will have their own bedroom. This property will be ready by 30/9/21. The Provider had submitted an application to vary the condition 8 of the current registration.	
Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Provider, PPIM and PIC will develop a centre risk register to ensure the identification, assessment and management of risks in the designated centre. All identified risks will be reviewed to ensure the appropriate risk rating is given to the risk and that all risks are identified on the risk register.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Provider has tendered for the fire doors, and the project will be awarded on 23rd October 2020. The Contractor will then order doors and install once manufactured. Individual personal emergency evacuation plans are now in place for each individual in the designated centre as well as a full assessment. 12 October 2020

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: All care plans in the designated centre had been reviewed to ensure that the residents needs have been identified through a formal assessment process and that there is a care intervention for each assessed need.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: All care plans have been reviewed to ensure that assessments and care interventions are consistent and reflective of the resident's current needs. The Provider and PIC will review the process of supporting residents to make decisions in relation to National Health Screening Programmes and ensure that this is clearly

documented in health care plan.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Provider has purchased a house and following renovations to the property one resident will move there as he had requested. All residents in the designated centre will then have their own bedrooms ensure their privacy and dignity is respected at all times. Both residents have been updated in relation to this plan and the timeframe for same.	

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	09/10/2020
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	30/12/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/12/2020

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	Red	30/09/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Red	30/09/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	09/10/2020
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	30/11/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Not Compliant	Orange	30/11/2020

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	12/10/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	25/01/2021
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	16/10/2020
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	16/10/2020
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Red	30/09/2021
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person	Not Compliant	Orange	16/10/2020

	maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
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.	Not Compliant	Orange	12/10/2020
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	12/10/2020
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is	Substantially Compliant	Yellow	12/10/2020

	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.			
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	12/10/2020
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	12/10/2020
Regulation 06(2)(e)	The person in charge shall ensure that residents are supported to access appropriate health information both within the residential service and as available within the wider community.	Substantially Compliant	Yellow	30/01/2021

Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/09/2021
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.	Not Compliant	Orange	30/09/2021