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:	St Laurence
Name of provider:	Enable Ireland Disability Services Limited
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	02 September 2019
Centre ID:	OSV-0005644
Fieldwork ID:	MON-0026795

About the designated centre

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

The designated centre provides full-time accommodation and support to adults with physical disabilities and neurological conditions. The designated centre is located on the outskirts of Cork city. It comprises a period house, nine self contained apartments and a four bedroom detached house adjacent to the main building. The main building contains a basement kitchen and laundry, a ground floor dining room, sitting room and offices / training rooms. Modern accommodation is linked to the ground and this comprises of a reception area, bedrooms for three residents, staff offices, therapy rooms, bathrooms and toilet facilities. The first floor, which did contain offices, was no longer in use. The nine self contained apartments are opposite the period building. All are ground floor level and wheelchair accessible, have a front and back door, with a small garden area to the front. Each apartment has a living room and kitchen area, bathroom, bedroom and hallway. One apartment has two bedrooms. The detached house has four bedrooms, each en-suite, a living area, a kitchen / dining room and bathing and shower rooms. The first floor consists of a bedroom and office space that are not utilised. This house is for residents who wish to transition to the community. The staff team was nurse led and comprised of nursing staff, social care workers and care support workers.

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
02 September 2019	08:30hrs to 18:00hrs	Michael O'Sullivan	Lead
02 September 2019	08:30hrs to 18:00hrs	Margaret O'Regan	Support

Views of people who use the service

The inspectors met with 11 residents on the day of inspection. While some residents stated they were lonely, many spoke of active and busy lives attending to activities that made them happy. Residents spoke fondly in relation to staff and talked of staff members they missed, who had previously worked with the service. Many residents spoke of the difficulty of supporting themselves as they got older and the greater dependence they have on staff. Some residents enjoyed the independence and privacy afforded to them by apartment living. These residents felt they had control over their own possessions and living space.

Residents were complimentary about the focus that the current management gave in facilitating them, the residents, to get out and about, go on holidays and engage in a lifestyle that brought them joy. Throughout the conversations between residents and inspectors, there was a clear sense of mutual respect between residents and staff. This manifested itself in the friendly greetings observed, the banter enjoyed between residents and staff and the overall relaxed atmosphere in the centre and those who worked there.

Capacity and capability

The registered provider is the legally responsible entity for ensuring good governance arrangements and appropriate management systems in a centre. Many aspects of the day to day operations of this centre were effective and inspectors could see there were improvements, resulting in an improved quality of life for residents. There were improvements in terms of resident choices and access to a fulfilling life style. Nevertheless, inspectors were not satisfied that the overall governance arrangements were adequate. This stemmed from the lack of progression from the interim/caretaker plan of 2017 to a more secure funding and governance arrangement.

In 2017 a Memorandum of Understanding between Enable Ireland (current registered provider), Cheshire Ireland (previous registered provider) and the Health Services Executive (HSE) (who provides the greater part of the funding of the centre) was agreed. When Enable Ireland took on the role of registered provider in 2017, they appointed an appropriately qualified and competent person to be in charge. This person was full-time in the post. Their skills, experience and leadership capacity brought about stability to the work environment and an improved quality of life for residents. For example, staff turnover was reduced and there was good staff continuity. When staff were sick or there were staffing demands, staff covered extra shifts. Inspectors observed a good team spirit. For residents, the enthusiasm and passion of the person in charge transferred to making their lives more

meaningful. There was an open attitude to fulfilling residents wishes, whether that was a holiday in New York, competing in Bocce and other ball games or maintaining a small garden outside their apartment.

The person in charge was supported in their role by an equally committed, experienced nurse manager who actively participated in the management of the centre. This person was on secondment from the HSE. This management person was key to enabling staff, both nursing and non nursing staff, to be upskilled and assume greater responsibility. This was evident in the suite of in-service training that had been provided. The inspectors reviewed well maintained and documented social and health care plans that the residents had.

While these improvements were noted and had impacted positively on the day to day business of the centre, there were still significant challenges around the overall governance. As identified on the last inspection in November 2017, there continued to be a lack of clarity around the lines of authority and accountability. Clear details of responsibilities for many areas of service provision had not progressed from the initial arrangements set out in 2017. This was for all intents and purposes to be an interim and transitional arrangement.

Significantly, there was confusion around lines of governance when it came to accessing funding. All staff, other than management, continued to be Cheshire employees and new employees were also added to the Cheshire payroll. The Human Resource department of Cheshire Ireland handled such recruitment issues but were not involved in the interviewing process. The staff files held in the centre were Cheshire Ireland files. The person in charge was employed by Enable Ireland and the person supporting the person in charge was a HSE employee. Cheshire Ireland continued to cover the costs of servicing heaters, call bells and similar equipment. Overall, there were no issues with this level of maintenance. The HSE had covered the costs of fire protection upgrading works. However, significant issues were present in relation to the premises. The registered provider representative was aware of these premises issues but was not in a position to address the matters, given the uncertainty that continued with regards to the longer term plan for the funding and the running of the centre. Premises issues are further discussed in this report under Quality and Safety. Inspectors were not assured that the registered provider, Enable Ireland Disability Services Limited, had governance over all things relating to the centre. For example, the vast majority of documentation carried the name of the previous HIQA registered provider, Cheshire Ireland. While this in itself had limited impact on the care of residents, it did add to the confusion around the provider's level of oversight. Cheshire Ireland was no longer involved in staff supervision but staff were employed under Cheshire Ireland policies. Staff supervision was carried out by Enable Ireland and Health Service Executive (HSE) staff.

A meeting was to take place on 8th August 2019 between the HSE, Cheshire Ireland and Enable Ireland, the three parties involved in the Memorandum of Understanding. However, this meeting was postponed. It was unclear if a rescheduled date was arranged. Dates were set for arrangements to be finalised for the full transfer of ownership from one entity to another and confirmation of funding

arrangements to be finalised with the HSE, only for the date of the transfer to be extended.

The ongoing uncertainty about the resources and management of the centre did impact on residents' rights and dignity. For example, as outlined further on in this report, people working in a day centre on site accessed their place of work by walking through residents' living areas. This arrangement was meant to be temporary when Enable Ireland became the registered provider; however, the practice had continued for three years. Persons who had no appointment or specific purpose in the designated centre, had access to communal areas of the centre. This matter was waiting to be resolved when a more permanent management arrangement was secured.

The matter of governance was discussed and documented at staff meetings and residents meetings. In fact, it was a regular agenda item, indicating that in house management, staff and residents were all aware of the uncertainty and were seeking clarity.

The statement of purpose did not accurately reflect the governance structure. In addition, the information with regard to the availability of services, namely physiotherapy, needed updating. Details with regards to how visitors were facilitated was not stated in the statement of purpose.

Following a review of the roster and from speaking with the person in charge, inspectors were satisfied that there were sufficient staffing resources to provide the required assistance and support for residents. The person in charge emphasised that staff leave was covered by a panel of regular relief staff. This avoided the need for agency staff thus minimising the impact for residents, of having staff on duty that were unknown to them and vice versa. Initiatives such as the creation of team leader positions had worked well. Each of the three team leaders took responsibility for supporting residents to establish goals. They also ensured that residents aspirations were realised through working co-operation with all staff. Due to the lack of clarity around funding and the aforementioned governance arrangements, one of these three team leaders positions was temporary. This lack of capacity to consolidate staffing structures further impacted on the quality of residents' experience of residing in the centre. There was evidence that the registered provider had written seeking funding to fill vacant posts including physiotherapy, dietetics, nursing, care workers and administrative roles. 10 of the 15 residents were over the age of 65 years and their support needs involved one to three staff members.

Significant investment had been made in securing nursing positions and upskilling nurses in the care of residents who were advancing in years. This included skills in dealing with the medical, nursing and social challenges that aging poses.

Regulation 14: Persons in charge

There was an appropriately qualified and experienced person in the role of person in charge.

Judgment: Compliant

Regulation 15: Staffing

The number, qualifications and skill-mix of staff was appropriate to the number and assessed needs of the residents. Nursing care was provided. Residents received continuity of care and support.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training, including refresher training, as part of a continuous professional development programme. Staff were appropriately supervised.

Judgment: Compliant

Regulation 23: Governance and management

The management structure was poorly defined. Inspectors were not assured that the lines of authority and accountability, the specific roles of the three entities involved in the Memorandum of Understanding, and details of who was responsible for what, were clearly detailed for all areas of service provision. Resources were required to ensure that the designated centre was designed and laid out to meet the assessed needs of residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

Not all matters required by Schedule 1 were accurately reflected in the statement of purpose.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

An effective complaints procedure was in place.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors were satisfied that notifications had been made to HIQA as required by regulation.

Judgment: Compliant

Regulation 30: Volunteers

The actions from the previous inspection had been addressed in relation to supervision of volunteers and provision of clarity around the roles and responsibilities of volunteers.

Judgment: Compliant

Quality and safety

The inspectors observed that significant improvements had taken place in the designated centre since the last HIQA inspection in November 2017. The managers and the staff based in the centre had very detailed and specific knowledge in relation to each resident and the main focus of service delivery related to better outcomes for residents. Both management and staff demonstrated a strong attitude of investment in the future of the service. The safety and protection of residents was prioritised. Matters of concern reported by residents as complaints, were promptly and appropriately investigated to conclusion and to the satisfaction of the resident. The general welfare and overall health needs of residents were promoted.

All residents that inspectors met with were very able in communicating both their assessed needs and their plans for the future. There was evidence that residents

had in date and recently revised individual care plans that clearly demonstrated collaboration with their named key worker. Residents were in attendance at annual and multidisciplinary care plan reviews. Goals and outcomes were accurately captured with the support of designated key workers. Goals defined were ambitious and adventurous, requiring significant staff flexibility and support. Each resident had a current health and safety risk assessment in place. Each resident was also assessed regarding their level of dependency which was based on their manual handling needs, clinical and medical needs, skin integrity, the level of staff intervention and supports, as well as the residents age.

Each resident had in place a health action plan which had been reviewed in the current year. Residents who were entitled to national screening programmes had availed of appointments and surgical interventions as a result. Residents had a choice of general practitioner. Overall, each resident was in receipt of multidisciplinary interventions, as required. The existing vacancy of a physiotherapy post meant that the mobility and seating needs of the residents who were all wheelchair users, were not met. This post had been unfilled for six months.

All residents were assessed to determine if they could safely self administer medication. The person in charge had a system in place to record and track all medication errors. Circumstances that had the capacity to cause error were clearly documented. The medication error and reporting system was subject to monthly review and clearly demonstrated when a error did not reach or impact adversely on the resident.

Some areas of the designated centre were in need of repair and remedial works both internally and externally. The fabric of the buildings in the apartments was subject to damage and wear and tear relating to the use of larger appliances and wheelchairs. The design and layout of the designated centre impacted on some residents accessibility and meant that some residents required greater staff presence and intervention to reduce isolation and solitary activities. Repair works, the sourcing of funding and the overall authority to make a determination on the future of the premises and infrastructure was impacted on by contractual governance and uncertainty between the registered provider, the former provider and the services primary funder. This was consistent with the findings of an inspection two years previously. A solution to provide kitchen facilities for three residents in the main house and the location of these resident's bedrooms in proximity to staff offices, staff break rooms and toilets remained at planning stage.

The registered provider had undertaken extensive fire works since the last inspection. These included the repair and installation of fire doors, the provision of alternative means of horizontal evacuation by introducing french windows and the installation of fire stop measures to ducting at ceiling level. Each resident had a current personal emergency evacuation plan and records reflected daily inspection of all fire exits and escape routes. Fire extinguishers, sprinkler systems, fire blankets, emergency lighting and the fire alarm panel had been recently serviced by an approved contractor. Fire drills had been conducted and recorded demonstrating acceptable evacuation times. The person in charge undertook to conduct fire

evacuation drills using minimum staffing levels.

Inspectors reviewed the current risk register and risk management policy for the designated centre. While these were up to date and all residents had an individual risk assessment in place, the paperwork reflected the current business arrangement for service delivery that was confusing. The risk management policy was in the name of the previous provider, the guidelines in relation to the policy were from the Health Services Executive (HSE) and the pathway was Enable Ireland - the current registered provider. The inspectors were informed that there was a memorandum of understanding between all three parties. These working arrangements and uncertainty were recorded in team meeting clearly as " governance is to be determined in the coming months between Enable Ireland and the HSE". There was no evidence that the registered provider addressed this identifiable risk or put in place control measures to ensure that it did not adversely impact on residents and their quality of life.

Each resident had an extensive informed decision making record in place. This included consent in relation to intimate care and the use of photographs and images. Residents spoken with on the day of inspection identified staff members and managers they would feel comfortable with if they needed to report concerns. There was evidence that the person in charge had taken appropriate action in relation to recorded allegations and all investigations were conducted to conclusion. Residents satisfaction with the outcome was recorded and one resident confirmed to inspectors verbally that their concerns had been dealt with.

Inspectors observed good hand hygiene practices in place and there were hand sanitizer stations located throughout the designated centre. Residents who required extra infection control measures had notes that accurately reflected the precautions to be taken and the cleaning regime. The procedures adopted were consistent and involved the expertise of external clinical advisers.

There was evidence that each resident participated and consented to supports in relation to decisions about their daily life. Residents stated that staff would knock or call out if they wished to enter the residents room or apartment. Each resident had a call pendant which they used to contact staff or alert staff if they required assistance. Many residents were supported to avail of continental holidays while one resident was actively planning a holiday in the United States of America, with their key worker. Residents also requested and availed of short term breaks in the registered providers respite service by the sea. The inspectors observed that the former provider had a community service in place adjacent to the designated centre where day attendees and staff access was through the designated centre. This access arrangement impacted on each resident living within the designated centre, who had no control over who entered or passed through their living areas.

Overall, inspectors observed residents to be involved in meaningful activities with some residents supported to attend day services in the community. Residents stated they felt safe and well cared for. Residents appeared to be comfortable in the presence of staff and interactions were observed to be respectful, friendly and unhurried. Residents pursued activities of interest and some were actively involved

in bocce which they stated they enjoyed. Some residents were at retirement age and felt their daily programme of activities suited them. They indicated that on some days they like to remain in bed until they felt ready to get up. Staff facilitated and supported the residents wishes in this regard. Three residents had their own personal cars that staff used to facilitate outings and excursions, specific to the individuals. Residents felt that they might have more social outings if the centre had one of the buses repaired. One resident stated that some plans had to be deferred if staff were not available. The limitation of one bus was an ongoing and unresolved issue.

Some residents had their own mobile phone while others used the office phone. Key workers and administrative staff assisted residents to purchase online food, clothing and items of personal choice. Each resident had their own television set and some had satellite service provision that they paid for themselves. Residents had access to DVDs and daily newspapers. The use of the internet was also facilitated in one of the services multifunction rooms.

Regulation 10: Communication

The registered provider ensured that each resident was assisted and supported to communicate in accordance with the residents' needs and wishes.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider did provide access to residents for occupation and recreation, however, supports to develop and maintain community links were sometimes limited by staffing and transport availability.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider did not ensure that the design and layout of the premises met the objectives of the service and the number and needs of residents. Some elements of the building fabric required repair and decoration.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place, however, contractual governance issues were not risk assessed or controls implemented, to ensure limited adverse impact on residents.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider ensured that residents at risk of healthcare infections were protected by the adoption infection control measures.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had an effective fire safety management system in place.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge ensured that the designated centre had appropriate and suitable practices in place for the ordering, receipt, prescribing, storing, disposal and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that each resident had an appropriate assessment of health, personal and social care needs in place that was subject to review.

Judgment: Compliant

Regulation 6: Health care

The registered provider ensured that each resident had an appropriate healthcare plan in place and that residents received appropriate allied health services.

Judgment: Compliant

Regulation 8: Protection

The registered provider ensured that each resident was assisted and supported to develop knowledge, self awareness and understanding for self-care and protection.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider ensured that the designated centre was operated in a manner that respected residents, however, the access through the designated centre to an adjacent community based service did not uphold resident's rights and dignity.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 30: Volunteers	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Laurence OSV-0005644

Inspection ID: MON-0026795

Date of inspection: 02/09/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Outstanding Governance issues have been escalated to both CEO's of the two voluntary organisations, Cheshire Ireland and Enable Ireland and the HSE Head of Social Care. Negotiations began in advance of the expiry of the first temporary agreement as outlined in the original 2017 memorandum of understanding. This was followed and continues to be processed through a series of written communiques in addition to circa ten meetings between the parties. This has culminated in the most recent engagement throughout September and October 2019 wherein financial figures pertaining to a final long term service agreement were validated in writing by HSE on 22.10.19. Enable Ireland now awaits agreement from HSE to fund same in addition to an undertaking on potential liabilities going forward in time to conclude the temporary memorandum of understanding on 25.10.19.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: SOP will be revised to reflect existing governance structure, physio services will not be included and arrangements for visitors will be clarified Completed by October, 31st. 2019.	

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Resident's communication passport has been updated with current staff information.
Transport provision is included in the governance negotiations with the HSE and in the meantime, 3 residents have access to their own vehicles. Transport arrangements for all residents are managed through the team leads and staffing arranged accordingly to support residents with outings. A robust relief panel supports the core staffing levels if staff are sick/annual leave.

Since the inspection on September 2nd , in the absence of a Physio therapy service, one resident has been reviewed by a geriatrician and subsequently referred to the falls clinic for physio services. One other resident is awaiting an appointment with the geriatrician. One further resident is being referred to day services for physio therapy.
A part time physio therapy service has been costed and submitted to the HSE for approval and this costing has been agreed with the HSE and will come into place along with the outstanding governance issues

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Cheshire Ireland are currently getting quotes to ensure separate access for their community service staff separate to the designated center.
Quotations and completion of works by April, 2020.

A building maintenance plan and budget is being agreed with HSE as part of the governance negotiations

Engineer report suggesting remedial works to plaster work to the outside/inside of the building has been summited to Cheshire Ireland for repair.

Regulation 26: Risk management	Substantially Compliant

procedures	
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Risk Management documentation will be altered to reflect registered providers Risk Management system in line with Governance. All risks that require follow up, are escalated to the senior health and safety managers of both organisations currently involved in the management of St Laurence.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Currently Cheshire Ireland are receiving quotes to move their entrance for community service staff to their 'wing' of the main building. A meeting with the Health and Safety/Risk manager is to be facilitated around this in relation to management of staff – sign in/fire logs, maintenance, training areas. Completion date: April, 2020	

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 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	30/04/2020
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	Orange	30/04/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Not Compliant	Orange	30/04/2020

	state of repair externally and internally.			
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.	Not Compliant	Orange	30/04/2020
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	30/04/2020
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	31/10/2019
Regulation 09(3)	The registered provider shall ensure that each	Substantially Compliant	Yellow	30/04/2020

	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.			