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:	Castletownbere Residential
Name of provider:	CoAction West Cork CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	14 June 2024
Centre ID:	OSV-0002108
Fieldwork ID:	MON-0043899

About the designated centre

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

The service provided is a social care model that bases residents in their local community. The service is for adults with an intellectual disability who require either residential or respite services. Residents have access to day services locally and are supported to access employment should they wish to. The premises of this centre consist of two pairs of semi-detached houses which have been joined internally. One of these has an extension to the rear. These houses are located on the outskirts of a rural town. These are located within a hundred metres of each other. Bedrooms are located on both the ground and first floor, with each bedroom having an en-suite. Some bedrooms have track hoists. Each house has their own kitchen and sitting room, which are adequate to provide suitable common space for the residents. Each house has a garden to the rear. The staff team comprises of social care workers and care assistants with a team leader supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 14 June 2024	09:00hrs to 17:30hrs	Lucia Power	Lead

What residents told us and what inspectors observed

Castletownbere is registered for 13 residents and the accommodation comprises of two units. One unit is to support seven respite residents and the other unit for six residential, however this unit has remained closed due to staffing resource issues.

On the morning of inspection there was three residents ready to head out for the day as part of their daily plan. One resident was just leaving when the inspector arrived but the other two residents spent some time with the inspector before they headed off.

One resident told the inspector they were going home and a family member was collecting them. They also told the inspector they enjoyed their time in respite and how they went to the local pub.

They also told the inspector that sometimes they play cards in this pub. Another resident told the inspector that they were going to work that morning and they were looking forward to it, they also told the inspector that they enjoy being in for respite and that staff are very good to them. For example they said that staff were kind and support them in the community

Both residents told the inspector that they have weekly meetings and that they had a fire drill the previous week. They also said that things had improved, and that the centre has been open every week since January 2024 and this is very important to them.

The inspector observed interactions between the residents and staff and it was seen that staff were very supportive and promoted resident independence. On the day of inspection the assistant director (person participating in management PPIM) and the director of services was present. The inspector saw that management knew the residents well and that the residents were very comfortable with them.

From discussing with residents and staff it was evident that residents were involved in their local community, the residents spoke about going to different places such as shops, pubs, picnics, walks and visits. Residents experienced work in places such as local library, hardware store, grocery, flower shop and other businesses. From speaking with residents and staff it was very clear that this was an important part of their life and also the role they play in their community. For example some residents are involved in the tidy towns.

The inspector met another resident in the afternoon of the inspection and they received a great welcome from staff when they came to the house. The staff on duty told the inspector that sometimes this resident does not feel comfortable with new people and spoken about in a very respectful manner.

The resident appeared quiet and went for the chair the inspector was sitting on as

this was their favourite spot, the resident was very familiar with their surrounding and it was observed that staff had a very good understanding of the residents needs and also told the inspector that the resident had a favourite spot sitting at the table.

The inspector met four staff and two managers, all were very supportive and understanding of supports the residents required, and some had worked with the residents for a number of years. It was seen that residents were very comfortable in the presence of staff.

Each resident has their own bedroom when on respite, however one resident was in the centre five nights per week, each week, which the provider referred to as respite. However the providers policy stated that a residential place was five nights or more. This resident bedroom had a label on the wardrobe with another persons name.

Areas of the centre required upgrading as some furniture was worn, some areas appeared distressed, for example rusty radiators, plaster peeling from wall and ceiling, and some areas required painting.

Overall it was seen that residents lived a good life, were involved in their local community, consulted in the running of the centre and were given choices.

However there were areas of improvement that are required in areas such as personal planning, assessed needs and rights. These will be discussed further in the report.

Capacity and capability

The provider had in place a management structure to oversee the governance and operations of the centre. The provider was in the process of putting a new person in charge in place and this was under review at the time of inspection. However the person participating in management was based in the centre one day per week and there was systems in place to support the monitoring of the centre, it was also noted on inspection that the provider was reviewing improvements that was required in the centre to meet the requirements of the regulation.

This centre had a previous inspection in April 2023 and there was a number of areas identified for improvement. There was not compliance's found in six areas, records, governance and management, notifications, premises, protection against infection and residents rights.

The purpose of this inspection was to follow up to determine if the provider had completed actions identified in the provider's compliance plan submitted to the chief inspector.

Between the previous and the current inspection the provider submitted two

compliance plan updates.

The inspector also reviewed the governance and management plan as due to changes in the organisations structure, assurances were required from the provider in relation to governance and management. The chief inspector wrote to the provider in January 2024 and received a response outlining measures the provider had, and was putting in place to ensure ongoing oversight and monitoring.

The provider had carried out an annual review and six monthly as is required by the regulation. This review had identified areas for improvement and the provider had developed a tracker to review same, which was a live action plan reviewed on an ongoing basis at management meetings.

There was some improvement noted on the day of inspection and the provider had put in place the structures outlined in their governance plan that was submitted to the chief inspector.

For example the provider identified an number of areas for oversight and put in place the following to ensure monitoring was in place - Regulatory oversight committee and Interim steering committee – these will be discussed further under governance and management.

Regulation 15: Staffing

The provider had ensured that the number and skill mix of staff was in place to support the assessed needs of residents. The inspector looked at the rotas in place from January 2024 and noted there was a consistency in staff. The inspector also observed and read documentation in relation to the staff identified for the shift on the day of inspection.

The Inspector requested staff files on the morning of inspection and was given these as requested. From the four files that the inspector looked at all documentation was in place as specified in schedule 2.

Judgment: Compliant

Regulation 16: Training and staff development

Staff are to have access to appropriate training including refresher training. The provider had identified gaps in training and told the inspector some of this could not be organised due to the some members of the management team having left the organisation, these management positions included quality and safety and HR. The

provider had identified the training requirements in the statement of purpose.

The inspector looked at the training logs the provider had in relation to staff training and noted the following:

- Fire safety-one staff required training.
- Managing behaviour that challenges-six out of eight staff required training updates in his area.
- Safeguarding-two out of eight staff required refresher training as it was noted to be out of date on the providers review.

There was also gaps noted in training relating to medication management and infection prevention and control.

The regulation also cites that staff are appropriately supervised. There was no supervisions for front line staff being provided. The provider had identified this as a gap and it was noted in the provider's audits as well as meeting notes that supervision was required for staff and how the provider can improve and implement this for learning and reflection.

Judgment: Not compliant

Regulation 19: Directory of residents

The provider did have a directory of residents in place and this was reviewed, however not all information was been maintained as part of this register and this will be discussed under regulation 21 records.

Judgment: Compliant

Regulation 21: Records

This regulation was also found not complaint on the previous inspection. From a review of the records the inspector saw that the provider had not consistently recorded dates during which a resident was not residing in the centre. Some entries had not been documented by the provider since May 2023.

It was also noted that the provider did not highlight the use of restrictions. On the day of inspection the inspector saw that there was a locked press which limited the residents access and there was no rationale as to why the presses required locking, some windows had restrictions. The provider is required under schedule 4 to make this known to the chief inspector.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector did note some improvements on the day of inspection and it was evident that the provider was making efforts to ensure effective oversight and monitoring.

For example the provider has highlighted in the governance and management assurance to the chief inspector that the assistant director of service would base themselves in the centre every Friday. This inspection was scheduled for a Friday and the person was present for the day, it was also evident from review of the visitors log and from speaking with staff and residents that this was consistent. Staff told the inspector that this was a good support.

The provider carried out the annual review and six monthly as is required by the regulation. The reviews contained improvements such as:

Consultation with residents
Review meaningful goals with residents
Training for staff
Maintenance work
Policy update

The inspector also noted that the above areas required oversight by the provider to come into compliance. There was evidence of a regulatory oversight committee and a tracker with all the actions identified was these were discussed at this meeting.

The director of services also met with members of the board on a weekly basis as part of the interim steering committee.While there was increased oversight and commitment from the local management team there was still a number of regulations that remained not compliant.

On the day of inspection it was found that:

- Premises work remained outstanding, with areas seen to be distressed, worn and rusty radiators. Areas of the centre required cleaning.
- Records were not been updated as per the schedule for example, details of when residents were in the centre, a number of files relating to this were not updated since May 2023.
- Records relating to restrictive practices as there was a locked press in the kitchen with no rationale as to why it was locked and window Restrictors on the windows without a clear reason
- Personal plans were not updated in line with the regulation and five out of the six files reviewed did not contain the updates.
- A resident's file was not updated to reflect changing needs.
- There was gaps in the training from staff and staff were not receiving

supervision.
The provider had not taking into account the rights of one resident in relation to tenancy.

However on balance the provider had put in place the governance and management plan submitted to the chief inspector in January 2024 but the current status in relation to resources was impacting the delivery of service.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had committed to updating contracts for the provision of services. Five contracts reviewed were updated for residents in line with the regulation.

However one contract had the service type as respite, this was for a resident who availed of five nights per week weekly. According to the providers own policy any resident who is five nights or more on a weekly basis is considered a residential placement as opposed to respite. The contract did not take into account the residents status. This will be discussed further under regulation 9 rights.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had in place a statement of purpose which contained the information as outlined under schedule 1, the inspector reviewed this and all information was contained in the statement of purpose. The provider also had updated the statement of purpose to reflect any changes. A copy of this statement must be made available to residents and its representatives. One the day of inspection the provider could not access the copy that was to be made available for residents. However by the end of the inspection the inspector observed the person participating in management making this available.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints procedure to effectively manage

complaints. The policy required review and this was noted under regulation 4 as the provider had not updated within the time frame specified in regulation 4. However the inspector looked at the complaints book and noted the last complaint was dated May 2024. It was noted that this was been reviewed by the provider and discussed with the residents. This complaint was ongoing. However it was noted that in previous complaints they were resolved to the satisfaction of the complainant.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider is required to prepare in writing and adopt and implement policies in line with schedule 5. The inspector looked at the providers polices and went through each one individually as cited in schedule 5. From review of the providers policies, the inspector noted that all policies required updating, some policies were due for update in 2021 and 2022 as per the providers time lines. The person participating in management confirmed that the provider was aware that the polices were out of date and that plans were in place to update.

Judgment: Not compliant

Quality and safety

The provider was committed to deliver a good service to residents but was experiencing some organisational difficulties, particularly in staff resources, for example one unit of the centre remained closed as they found it difficult to employ staff. Also in the last number of months there was gaps in the senior management team, such as CEO, finance, HR and Quality who had left the organisation.

The provider had identified in the centre risk assessment that there could be poor service provision for residents due to not been able to recruit and despite a number of recruitment drives there were unable to open the second unit.

The person in charge was also out on extended leave and another potential person in charge has been identified. This was having an impact on the providers ability to meet the regulations. It was also noted in the providers statement of purpose that the person in charge would be 0.8 WTE, the regulation requires the person in charge to be full time position.

When reviewing records the inspector saw and noted gaps in records and personal plans, these were not updated to reflect the wishes and assessed needs of residents.

The provider had met with resident representatives during 2024 to provide an update in areas such as recruitment and service delivery. The inspector asked if residents were aware of this meeting and had they been informed. From speaking with residents they told the inspector they were aware of this consultation with their representatives.

The provider had submitted a plan to the resident representatives re the future needs of the service.

Overall the residents were happy and in receipt of a more consistent service.

Regulation 13: General welfare and development

Residents had access to facilities for occupation and recreation. The residents were very involved in their community and from speaking with residents they enjoy these activities. On the morning of inspection one resident was going to the hub based in their local community, another resident was going to work in the local library.

It was also noted from discussion with staff and from a review of documentation that other residents enjoyed jobs in places such as the local post office, the flower shop, beauty shop, hardware store and one resident had retired from the local golf club.

Some residents were involved in the local tidy towns and residents also told the inspector they like going to the local pub and playing cards and pool. It was also noted that residents got to visit friends and avail of training in the community. One resident had completed a cookery course in the education training board and was been supported to practice these skills at home.

It was evident from speaking with residents and staff that they had good links with the wider community.

Judgment: Compliant

Regulation 17: Premises

Premises was found not complaint in the previous inspection and the provider had committed to addressing this in their compliance plan response. The inspector did a walk around of the centre with the person participating in management and while there was some improvement there was still concerns in relation to the premises. For example on the day of inspection the inspector noted:

- Majority of radiators in one house (comprises two units) were rusty.
- There was mould appearing in some areas of the bathroom areas.

- Wall plaster in some shower rooms had fallen off.
- .Some areas of shower rooms required grouting.
- Areas of one house around the door area was visibly dirty.
- Furniture and fittings appeared old and distressed

The inspector showed the PPIM these areas and the PPIM clarified that a maintenance log was put into the provider and they are awaiting follow up.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had systems in place in the designated centre for the assessment, management and ongoing review of risk.

The inspector looked at the provider list related to risk and these were all updated April 2024. High risk was identified for:

- Poor service provision due to lack of staffing.
- Training not consistently updated.
- Lack of HR and quality support.

The provider had identified these risks and had put measures in place and were part of ongoing review.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge is to ensure that the personal plan is subject to an annual review and ensures the maximum participation for the resident in line with their wishes, this plan is also to be assessed for effectiveness. On the day of inspection the inspector looked at six files and noted that only one resident was subject to the annual review. It was also noted that there was no review of the goals and for some the goals were not identified. Some goals related to visiting the GP, visit a friend, and go out for dinner and to stay healthy. These goals are part of residents everyday activities and more work was required to ensure the goal were meaningful to residents.

It was also noted that one resident had a changing need and had an assessment carried out in October 2023. There was no evidence that the resident's plans were updated to reflect this changing need and no review of their behavioural support plan which was dated May 2020.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had appropriate health care supports in place for residents. The inspector looked at six files and noted that Health care plans were in place to support residents with their identified medical and health needs. There was also a review by the community nurse in March 2024. The inspector also spoke to some residents who told the inspector that they were well supported in this area.

Judgment: Compliant

Regulation 9: Residents' rights

The residents had weekly meetings and the inspector looked at meting notes in relation to four meetings. It was evident that resident were being consulted and updated about the centre. The meeting format discussed activities and planning, food preference, fire safety and some organisational updates.

However it was noted that one resident's right pertaining to their home required review. This resident has a tenancy registration number, their contract of service was specified as respite, and however they were in the centre five nights per week, every week.

In line with the providers policy any resident five nights or over was considered residential not respite. The provider was asked by the inspector if any other resident was registered with the tenancy board and how this impacted their rights within their home. The provider was to follow up on this query and revert back post inspection.

However it was noted that the rights of residents was respected by staff.

It was also documented that residents had access to advocacy services.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Castletownbere Residential OSV-0002108

Inspection ID: MON-0043899

Date of inspection: 14/06/2024

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff Supervisions to be conducted and will be completed in July/August 2024 with all staff in the designated centre. Staff will be supervised appropriately going forward. A schedule of supervisions within the designated centre will be completed for the year by the end of July 2024. All staffing training gaps have been identified and training sourced for all staff. A schedule will be drafted to make sure that all staff have the mandatory training. Monitoring of the training matrix for the designated centre will be held with the incoming PIC who will source any training coming out of date.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Directory of Residents will be updated in line with requirements to accurately reflecting the dates of residents residing in the centre. This is scheduled for the 26th of July 2024. The locked press holding cleaning products has been removed and if required to be locked, a restrictive practice will be processed through the Committee. A submission for the Window Restrictors will be submitted for the Restrictive Practice Committee on the 16th of July 2024.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A walk around the centre is schedule for the end of July 2024 with the incoming PIC and	

maintenance to review any outstanding items requiring repair. A schedule of repairs will be required following this.

Directory of Residents will be updated in line with requirements to accurately reflecting the dates of residents residing in the centre. This is scheduled for the 12th of July 2024.

The locked press holding cleaning products has been removed and if required to be locked, a restrictive practice will be processed through the Committee. A submission for the Window Restrictors will be submitted for the Restrictive Practice Committee on the 16th of July 2024.

The Personal Centred Plans will be reviewed at the local managers meeting and a plan for updating these consistently will be devised.

A Full File review is scheduled with the incoming Person in Charge for the 26th of July 2024 with the Assistant Director of Services. Any change of need will be updated accordingly during this file review.

As per CoAction's policy, one resident will have their contract of care changed to resident however due to the restrictions in staffing, the centre will remain open Wednesday to Monday until such time additional staffing is sourced to open the centre full time.

Staff Supervisions to be conducted and will be completed in July/August 2024 with all staff in the designated centre. Staff will be supervised appropriately going forward. A schedule of supervisions within the designated centre will be completed for the year by the end of July 2024.

All staffing training gaps have been identified and training sourced for all staff. A schedule will be drafted to make sure that all staff have the mandatory training. Monitoring of the training matrix for the designated centre will be held with the incoming PIC who will source any training coming out of date.

A review of the 0.8 WTE will be completed for the incoming Person in Charge by Finance and Senior Management. Once completed, this will be amended and reflected within the Statement of Purpose.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A scheduled review of Policies is currently underway within the organisation. Upon the policies being updated, these will be replaced within the designated centre's copy of the policies. The Policy Review Group will be sitting on the 17th of July 2024 during which the schedule will be set for the review of the policies.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

A schedule of works is being compiled with a walk around on the 26th of July by the PPIM. This will be submitted to the project manager to complete the required works and a schedule of when these works will be completed. This will include the mould one bathroom, wall plastering, regrouting in some bathrooms and some repainting.

A thorough clean of the house will be organised and the cleaning schedule bolstered to ensure the house remains clean. Further, replacement of some furniture's and fittings will be completed to replace some of the older items and to refresh the house.

Consultation with the residents on the replacement of some furnishings will be complete by the end of July through the weekly house meetings. Following from this consultation and in conjunction with the residents wishes, some items will be replaced.

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:
A full review of the Placement Centred Plans will be conducted in conjunction with their keyworkers and day services keyworkers. Once completed, a review by the PPIM to ensure that the goals are meaningful in the residents lives. At the next local managers meeting, it is on the agenda to discuss how the update on goals are documented and in what timeframe these are documented in.

For one resident, a review of his Behaviour Support Plan is underway alongside a review of his folder to reflect the change in need for this resident.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A contract of care as a resident will be issued to the person discussed during the inspection with the condition that the centre is currently open only 5 days per week.

The PPIM has queried with the Finance Department regarding the tenancy of any other residents. Once this information has been sourced, a copy will be provided to the inspectorate.

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 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	31/08/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/08/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/09/2024
Regulation 17(1)(c)	The registered provider shall ensure the premises of the	Not Compliant	Orange	30/09/2024

	designated centre are clean and suitably decorated.			
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	12/08/2024
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	30/09/2024
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	30/09/2024
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 Compliant	Orange	17/07/2024

	not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/09/2024
Regulation 05(6)(b)	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 conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	30/09/2024
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a	Not Compliant	Orange	30/09/2024

	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.	Not Compliant	Orange	30/09/2024
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	30/09/2024
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review	Not Compliant	Orange	30/09/2024

	carried out pursuant to paragraph (6).			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	30/09/2024