



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

Issued by the Chief Inspector

Name of designated centre:	Ballyduff Park
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	05 July 2022
Centre ID:	OSV-0002519
Fieldwork ID:	MON-0036796

About the designated centre

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

The designated centre provides a full time residential service to seven adults with an intellectual disability, both male and female. The centre is a purpose built eight bedroom house located in a small housing estate close to the nearest town. Staffing is provided over 24 hours, and there is a nurse on duty most week days. Residents attend various day services and activities, and there is a vehicle available for their use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7
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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
Tuesday 5 July 2022	09:15hrs to 15:00hrs	Úna McDermott	Lead
Tuesday 5 July 2022	09:15hrs to 15:00hrs	Stevan Orme	Support

What residents told us and what inspectors observed

This centre is run by the Health Service Executive (HSE) in Community Healthcare Organisation Area 1 (CHO1). Due to concerns about the management of safeguarding concerns and overall governance and oversight of HSE centres in Co. Donegal, the Chief Inspector undertook a review of all HSE centres in Donegal. This included a targeted inspection programme which took place over two weeks in January 2022 and focused on Regulation 7 (Positive behaviour support), Regulation 8 (Protection) and Regulation 23 (Governance and management). The overview report of this review has been published on the HIQA website. In response to the findings of this review, the HSE submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented, as set out by the HSE, but also to assess whether the actions of the HSE have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in Co. Donegal.

At the time of the inspection, some of the actions outlined above had commenced and others were completed. These will be discussed in the other sections of the report.

Ballyduff Park was located in a housing estate in a border town. It was within walking distance of a shop and close to other community amenities. The house was a spacious bungalow with a large bright entrance area where seating was provided. There was a large kitchen and dining area with views of the garden. There were two sitting rooms available which meant that residents had a choice of where to spend their time. The inspectors noted that the premises was homely, clean and personalised with photographs and soft furnishings. The bedrooms that the inspector observed were noted to be personalised and decorated in line with residents' wishes and interests.

On the morning of inspection, most residents were in the sitting room. Some residents told the inspector that they were waiting for transport to arrive so that they could go to their day service. Two residents were staying at home for the day and had centre based activities planned. Another resident was at home with their family. Residents spoken with said that they liked living in the centre and that things were well. One resident spoke to the inspector about topics of interest to them, such as going out for lunch and going to their day service. Another resident spoke about meeting with their brother and that they enjoyed their day. The staff member on duty told the inspectors that a trip to Dublin was planned for the following weekend and that the residents were looking forward to it. Other residents also spoke about contact with their families. It was evident that this was important to them, valued highly and that staff support was provided in order to facilitate this contact.

There was one staff member on duty and a second member of staff arrived shortly

after the inspectors' arrival. Staff were observed to be supporting residents in a caring and respectful manner. There was a warm and friendly atmosphere in the house. Interactions observed between residents and staff were respectful and engaging. As previously mentioned, two residents remained at their home on the day of inspection. One resident was observed moving from room to room and completing tasks of their choice. A second resident had a sleep in and they came to greet the inspectors on rising. They spoke about a recent trip to the hairdresser, which they appeared to enjoy.

In general, the inspector found that the service provided a quality, safe and person-centred service to residents. The residents living at Ballyduff appeared relaxed in their environment and had meaningful activities planned for their day.

The following sections of this report outline the governance and management arrangements and how this impacts on the quality and safety of care provided to residents.

Capacity and capability

As outlined above, this inspection was carried out to monitor compliance with the regulations and to review the provider's actions from the targeted inspections completed in January 2022. The inspectors found that there was a good organisational structure in place with clear lines of accountability and that there were arrangements in place for monitoring and auditing at the centre. However, improvements were required in a number of areas including the written policies and procedures used, training and staff development and risk management procedures.

The person in charge worked full-time and was responsible for one other designated centre in the county. They informed the inspectors about actions that had been implemented as part of the provider's action plan from the overview report. In relation to governance and management, 11 actions were completed. For example, there was a change in the reporting structure since the last inspection. Previously, the person in charge reported to two directors of nursing as the two designated centres under their remit were based in different network areas. This arrangement had changed. This meant that the person in charge now reported to one director of nursing and that both centres were based in the same network area. This was working well. At centre level, staff governance meetings were taking place every two months and the person in charge was meeting with their line manager on a monthly basis. At network level, governance meetings had commenced in relation to quality, safety and service improvement (QSSIM). The safeguarding review meeting was included as part the QSSIM agenda. The person in charge reported that this provided opportunities for shared learning, advice and support. At county level, the person in charge meetings had commenced and there was evidence provided that these were taking place every two weeks. These meetings provided opportunities

for discussion on current issues and/or concerns and included guest speaker presentations. The person in charge also attended the policy, procedure, protocol and guidelines development group (PPPG) during which policies, procedures and guidelines were reviewed and updated.

A range of audits were in use in Ballyduff Park and a review of these had commenced at CHO1 level. Mandatory audits were used and in addition, there were two service specific audits in use in relation to auditing residents' financial safety and auditing the accidents and incidents that may occur in the service.

The annual review of care and support was completed in October 2021 and included contributions from residents and their families. The six monthly provider-led audit was completed in April this year when an unannounced visit took place. Actions highlighted through both of these governance processes were highlighted in the designated centres quality improvement plan.

A review of the policies and procedures available for staff was completed. The inspectors found that although most were subject to regular review, two were out of date. These included the policy on the provision of behavioural support and the policy on staff training and development. The person in charge explained that these matters had been highlighted through the person in charge meetings held at county level and escalated to the policy development group. This showed that there were systems in place to highlight such gaps in the service provided.

The staffing arrangements in the centre were reviewed as part of the inspection. The skill-mix detailed in the statement of purpose (SOP) included nursing staff and healthcare assistants. There was a planned and actual rota in place which showed that there were a sufficient number of staff on duty to support residents. There was a minimum of two staff required at any onetime and there was evidence that further staff were provided if required for example, for the planned trip to the zoo. There was an on-call arrangement in place from which a consistent group of agency staff were available to provide support if required. This showed that residents received continuity of care and support. Furthermore, the person in charge was aware of the changing needs of the residents at this centre and a plan was in place to recruit further staff members to ensure that these needs were met.

Staff training and development was reviewed. The provider had a list of mandatory training that staff were required to complete as part of their continuous professional development and a training matrix was in place. The inspectors found that there were gaps in the completion of some refresher training programmes. These included refresher training in positive behaviour support, safe administration of medications and in particular safe administration of emergency epilepsy medications. The latter refresher module was essential to the assessed needs of the residents in this service to ensure that a safe service was provided.

The provider had a system in place for the recording of incidents and accidents that may occur in the centre. This provided evidence that matters arising were effectively documented and furthermore, that relevant notifications were submitted to the chief inspector in a timely manner in line with the requirements of the regulations.

The provider had a complaints policy in place which was available in easy-to-read format. It was up-to-date and provided clear guidance for staff and residents. The inspectors found that when a complaint occurred that it was recorded appropriately, investigated promptly and in line with the providers policy. A right of appeal was included in this process.

Overall, the inspector found that the staff recruited and trained to work in this centre, along with good governance arrangements ensured that in the main, a safe and effective service was provided in this centre.

Regulation 15: Staffing

The provider had ensured that the number, qualifications and skill mix of staff employed was appropriate to the number and assessed needs of the residents and the size and statement of purpose of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training including refresher training as part of a continuous professional development programme and a training matrix was in place. The inspectors found that there were gaps in the completion of some refresher training programmes. These included:

- refresher training in positive behaviour support,
- safe administration of medications and in particular
- safe administration of emergency epilepsy medications

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 11 actions aimed at improving governance arrangements at the centre. Ten actions related to various governance meetings at county, network and centre level and one action related to a review of audits within CHO 1.

On the day of inspection the person in charge told the inspectors that 11 actions in relation to governance and management had been implemented as part of the provider's action plan from the overview report.

- There was a change in the reporting structure since the last inspection. Previously, the person in charge reported to two directors of nursing as the two designated centres under their remit were based in different network areas. The person in charge now reported to one director of nursing and that both centres were based in the same network area. This was reported to be working well.
- At centre level, staff governance meetings were taking place every two months and the person in charge was meeting with their line manager on a monthly basis.
- At network level, governance meetings had commenced in relation to quality, safety and service improvement (QSSIM). The safeguarding review meeting was included as part the QSSIM agenda. The person in charge reported that this provided opportunities for shared learning, advice and support.
- At county level, the person in charge meetings had commenced and there was evidence provided that these were taking place every two weeks. These meetings provided opportunities for discussion on current issues and/or concerns and included guest speaker presentations. The person in charge also attended the policy, procedure, protocol and guidelines development group (PPPG) during which policies, procedures and guidelines were reviewed and updated.
- A range of audits were in use in Ballyduff Park and a review of these had commenced at CHO1 level. Mandatory audits were used and in addition, there were two service specific audits in use in relation to auditing residents' financial safety and auditing the accidents and incidents that may occur in the service.

The annual review of care and support was completed in October 2021 and included contributions from residents and their families. The six monthly provider-led audit was completed in April this year when an unannounced visit took place. Actions highlighted through both of these governance processes were highlighted in the designated centres quality improvement plan.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that notifications were submitted to the chief inspector in a timely manner and in line with the requirements of the regulation.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy in place which was available in easy-to-read format. It was up-to-date and when a complaint occurred it was recorded appropriately, investigated promptly and in line with the providers policy. A right of appeal was included.

Judgment: Compliant

Regulation 4: Written policies and procedures

A review of the policies and procedures available for staff was completed. The inspectors found that although most were subject to regular review, two were out of date. These included:

- the policy on the provision of behavioural support
- the policy on staff training and development

Judgment: Substantially compliant

Quality and safety

The inspector found that residents living in Ballyduff Park were provided with a person-centred service which strived to ensure that residents' wellbeing and personal needs were met. However, improvements were required to ensure that policies, procedures and training was up-to-date, and that all risks identified had a corresponding risk assessment.

The inspectors reviewed a sample of residents' care and support plans. It was found that annual review meetings took place with the maximum participation of residents and their representatives, where relevant. Residents were found to have up-to-date assessments completed of their health, personal and social care needs and these were available in easy-to-read format. Individual goals were set and there was evidence that these were regularly reviewed and updated accordingly.

Residents were supported to achieve the best possible health and wellbeing. They had access to a general practitioner and to a variety of allied healthcare professionals in accordance with their assessed needs. Multidisciplinary meetings took place if required. There was evidence of ongoing monitoring of identified health risks, such as regular access to consultant led services for example, for a resident that required cardiac care. Furthermore, residents had access to national screening

services if they were eligible for such supports and end-of-life care planning had been discussed with residents, as appropriate.

Residents that required support with behaviours of concern had positive behaviour support plans in place. These were reviewed and updated regularly. Restrictive practices were in use in this centre and a site specific restrictive practice . Furthermore, a restrictive practice log was in use and this was reviewed quarterly. This was an action put in place by the provider as part of their compliance plan submitted. There were six further actions in relation to positive behaviour support and the inspector found that five of these were fully implemented and one was implemented partially. This related to the fact that access to additional psychological supports was not available at the time of inspection. However, a recruitment campaign was on going in this regard.

Safeguarding practices used in this centre were reviewed and the inspector found that residents were adequately safeguarded against potential abuse. The provider had a safeguarding policy in place and this was up-to-date and reviewed regularly. Where a concern arose, this was followed up on promptly by the person in charge and in line with safeguarding procedures. Safeguarding plans were developed as required. Safeguarding was a standing agenda item on the staff governance meetings which were held in the centre. All staff had training in safeguarding and protection of vulnerable adults and access to designated officers was provided. As part of the provider's compliance plan, a safeguarding tracker was to be introduced for each network area by the end of March 2022. At the time of this inspection, the safeguarding tracking log was in use and the additional weekly cross referencing of incidents had commenced. Training on preliminary screening of safeguarding concerns was provided and reported to be very helpful. Of the 13 actions proposed by the provider, there was evidence that 13 of these actions were completed. This included the peer support structure for designated officers which reported to be formalised, supportive and that a plan was in place to for further staff to complete the designated officer training.

On a previous inspection, residents at Ballyduff Park were found to be at home and completing household chores. On the day of this inspection, the inspectors found that all residents had meaningful plans for their day. As previously stated most residents were attending day services and two residents were staying at home. Some residents had hospital appointments. There was an easy-to-read picture based activity and chore board which assisted residents to plan for their day. Furthermore, residents meetings were taking place regularly and activities and trips were a standing item on the agenda for these meetings. The inspectors found that this was a positive improvement in the service provided.

There were systems and procedures in place for risk management and risk escalation. In general, each resident had been assessed for any risks that may impact their safety and well-being and risk assessments were up-to-date, clear and reflective of local issues. The risk management policy was up to date. However, the inspectors found that a risk identified in relation to resident absconding did not have a corresponding risk assessment in place and this required review.

This designated centre operated in a way that respected the rights of the people living there. The provider ensured that residents had opportunities to make decisions about their care and support. This occurred informally on a day to day basis and formally through weekly residents meetings. An easy-to-read pictorial agenda and minutes were available for review and there was evidence that these minutes had been completed by individual residents. Human rights was a standing item on the agenda and easy-to-read booklets on human rights were reviewed.

Regulation 13: General welfare and development

The provider ensured that residents had appropriate care and support in relation to access to facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and wishes.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems and procedures in place for risk management and risk escalation. In general, each resident had been assessed for any risks that may impact their safety and well-being and risk assessments were up-to-date, clear and reflective of local issues. The risk management policy was up to date. However, the inspectors found that a risk identified in relation to resident absconding did not have a corresponding risk assessment in place and this required review.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' had up-to-date annual review meetings which took place with the maximum participation of residents and their representatives, where relevant. Residents were found to have up-to-date assessments completed of their health, personal and social care needs and these were available in easy-to-read format. Individual goals were set and there was evidence that these were regularly reviewed and updated accordingly.

Judgment: Compliant

Regulation 6: Health care

Residents' had access to a general practitioner and to a variety of allied healthcare professionals in accordance with their assessed needs. Multidisciplinary meetings took place if required. There was evidence of ongoing monitoring of identified health risks, such as regular access to consultant led services for example, for a resident that required cardiac care. Furthermore, residents had access to national screening services if they were eligible for such supports and end-of-life care planning had been discussed with residents, as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving governance arrangements in relation to positive behavioural support. One action related to multi-disciplinary supports, three actions related to staff training and in ensuring staff had adequate knowledge about behaviour support plans and three actions related to the induction of new staff.

The inspectors found that residents that required support with behaviours of concern had positive behaviour support plans in place. These were reviewed and updated regularly. Restrictive practices were in use in this centre and a site specific restrictive practice . Furthermore, a restrictive practice log was in use and this was reviewed quarterly. This was an action put in place by the provider as part of their compliance plan submitted and referred to above. There were six further actions in relation to positive behaviour support and the inspector found that five of these were fully implemented and one was implemented partially. This related to the following:

- access to additional psychological supports was not available at the time of inspection.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 13 actions aimed at improving

governance arrangements in relation to safeguarding and protection.

Safeguarding practices used in this centre were reviewed and the inspector found that residents were adequately safeguarded against potential abuse. The provider had a safeguarding policy in place and this was up-to-date and reviewed regularly. Where a concern arose, this was followed up on promptly by the person in charge and in line with safeguarding procedures. Safeguarding plans were developed as required. Safeguarding was a standing agenda item on the staff governance meetings which were held in the centre. All staff had training in safeguarding and protection of vulnerable adults and access to designated officers was provided. As part of the provider's compliance plan, a safeguarding tracker was to be introduced for each network area by the end of March 2022. At the time of this inspection, the safeguarding tracking log was in use and the additional weekly cross referencing of incidents had commenced. Training on preliminary screening of safeguarding concerns was provided and reported to be very helpful. Of the 13 actions proposed by the provider, there was evidence that 13 of these actions were completed. This included the peer support structure for designated officers which reported to be formalised, supportive and that a plan was in place to for further staff to complete the designated officer training.

Judgment: Compliant

Regulation 9: Residents' rights

This designated centre operated in a way that respected the rights of the people living their. The provider ensured that residents had opportunities to make decisions about their care and support. This occurred through weekly residents meetings. An easy-to-read pictorial agenda and minutes were available for review and there was evidence that these minutes had been completed by individual residents. Human rights was a standing item on the agenda and easy-to-read booklets on human rights were reviewed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ballyduff Park OSV-0002519

Inspection ID: MON-0036796

Date of inspection: 05/07/2022

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>To ensure compliance with regulation 16: Training and staff development: the following actions will be taken</p> <ul style="list-style-type: none"> • Positive behavior support – Two staff require day 2 training, scheduled 27/07/2022. One staff requires refresher training, this will be completed by 31/10/2022 • Safeguarding – All staff trained in Safeguarding, most recent training date 22/06/2022 • Buccal Midazolam – Two staff require training, date scheduled 23/08/2022 	
Regulation 4: Written policies and procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</p> <p>To ensure compliance with regulation 4: Written policies and procedures: the following actions will be taken</p> <ul style="list-style-type: none"> • Policy and Procedures on Positive Behaviour Support For HSE Intellectual Disability Services, Donegal. Revised 13/06/2022, available on site 27/07/2022 • HSE Intellectual Disability Services Donegal Staff Training and Development Policy and Procedure. Revised April 2022, available on site 27/07/2022 	

Regulation 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>To ensure compliance with regulation 26: Risk Management procedures: the following actions will be taken</p> <ul style="list-style-type: none"> • Individualised risk assessment completed in relation to resident absconding. Completed 05/07/2022 	
Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <p>To ensure compliance with regulation 7: Positive Behavioural Support: the following actions will be taken</p> <ul style="list-style-type: none"> • Positive behavior support – Two staff require day 2 training, scheduled 27/07/2022. One staff requires refresher training, this will be completed by 31/10/2022 • Policy and Procedures on Positive Behaviour Support For HSE Intellectual Disability Services, Donegal. Revised 13/06/2022, available on site 27/07/2022 • ID Psychology and Mental Health Team contacted by PIC requesting recommendation for external psychologist who could support individual resident. One name obtained, referral to be submitted to this person or another recommended psychologist by 30/11/2022. 	

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.	Substantially Compliant	Yellow	31/10/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	05/07/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as	Substantially Compliant	Yellow	27/07/2022

	often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/11/2022