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:	Waterford Cheshire
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Waterford
Type of inspection:	Announced
Date of inspection:	16 January 2023
Centre ID:	OSV-0003457
Fieldwork ID:	MON-0030373

About the designated centre

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

Waterford Cheshire was established in 2003 and provides accommodation and support in a purpose-built facility of self-contained apartments to adults with physical disabilities and neurological conditions. Individuals seeking to access services must be aged between 18 and 65 when they first arrive.
The service can accommodate 16 Service Users in total. Fourteen permanent residential apartments are available and two apartments are used to provide respite services. Most of the apartments have one bedroom, some have two bedrooms. All apartments have a kitchen/dining room and accessible bathroom.
Many of the people accessing the service have high physical support needs and the service endeavours to provide the supports required to enable each person to maintain the best possible health and to remain as independent as possible, for as long as possible. People living in the centre direct and participate in their own care.
The centre operates all year round and is staffed 24/7. A mix of nursing and support workers provide assistance to residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
Monday 16 January 2023	09:00hrs to 17:00hrs	Sarah Mockler	Lead
Monday 16 January 2023	09:00hrs to 17:00hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This was an announced inspection completed to support a decision regarding the renewal of the centre's registration. Two inspectors completed the inspection over the course of one day. The inspectors found serious concerns relating to the safety of care provided to residents over the course of the inspection and issued immediate actions to the registered provider in relation to fire safety in particular.

The centre is registered for a maximum of 16 residents, of which two beds are registered for a number of individuals to avail of respite services. On the day of inspection there were 13 individuals living in the centre on a full-time basis. Both respite beds were unoccupied at the time of inspection. The inspectors had the opportunity to meet with 11 residents, to speak to staff and to the centre management team except for the person in charge who was unavailable on the day. Inspectors visited all aspects of the premises and visited each of the apartments that comprise the centre in addition to reviewing documentation in one of the centre's large communal areas. Over the course of the day residents came to speak to the inspectors or inspectors met them in their individual apartments.

Nine of the 11 residents who met with inspectors expressed their concern regarding levels of staff support in the centre and gave examples of times they had to wait to receive care and support. Residents spoke of their anxiety regarding their skin integrity or what may happen if they fell. A resident spoke of not having the physical skill to open doors and waiting for staff if they needed to move. Other residents spoke of how personal care such as showering had to be scheduled in advance and that this was often delayed if there was insufficient staffing. Residents told the inspectors that they liked the staff who worked with them however, they were aware that staff did not all have the training or knowledge to attend to their particular needs. Two residents spoke of how there was a need for staff to be aware of the impact of their particular diagnosis on how they presented and what was needed to maintain their dignity while in receipt of care and support.

The inspectors also had the opportunity to meet with a number of the staff team over the course of the day. The staff were observed to be caring and respectful with residents. They knocked prior to entering an apartment, staff checked for resident's permission prior to carrying out a care task and engaged with residents in a caring but fun manner. Where individuals had specific communication needs staff demonstrated skills in this such as using Irish Sign language, using high-tech augmentative and alternative communication systems and support in managing hearing aids and other assistive technology.

As this inspection was announced residents had been encouraged to share their views via the use of questionnaires that had been sent in advance. The responses captured on these included that residents were concerned regarding the cost of living in the centre with multiple costs that they had to budget for. Again residents highlighted that they were concerned in relation to the number of staff available to

support them.

As part of the inspection process the inspectors completed a walk around of the premises. As part of this walk around inspectors reviewed empty apartments, residents' individual apartments, and communal spaces. Each resident within the centre had their own individual space, they had an en-suite bedroom, a small kitchen and living area. It was evident that each space was individualised to each person's preference and taste. A resident who was very interested in interior design happily spoke about how they decorated their own apartment. However, although some individual apartments were very well maintained, other individual apartments, empty apartments and storage spaces were not found to be in an optimal condition and posed risks from an infection prevention and control (IPC) perspective. This is discussed in more detail throughout the report.

Serious concerns were identified in relation to aspects of safety of care within this centre. Immediate actions were issued in relation to fire safety and the provider was required to provide written assurances following the inspection. The next two sections of the report discuss these findings in more detail.

Capacity and capability

The arrangements in place to ensure effective governance in this centre were found inadequate in some key areas of safety of care. A number of improvements were required in relation to staffing, staff training and aspects of local and provider level oversight to ensure the service was best meeting the needs of the residents.

An immediate action was issued on the day of inspection in relation to fire containment within the home. This is further discussed under Regulation 28. The provider had demonstrated poor oversight in relation to ensuring effective fire containment within the centre and limited actions had been taken to rectify the issues. The following day a written request to the provider was issued to ensure effective actions had been taken.

There were clear lines of authority and accountability within the centre. There was a full-time person in charge appointed to the centre. They were unavailable on the day of inspection. The inspection was facilitated by the regional manager who was also one of the appointed person participating in management of the service.

A recent roster review had been completed by the provider and new roster was due to roll out in February 2023. The aim of the roster review was to ensure that staffing was appropriate to meet the needs of the residents. However, from discussions with residents, and review of documentation the inspectors were not assured that the number of staff available were adequate to meet residents' specific care needs. Residents clearly articulated their concerns in relation to this and were able to give specific examples of how the number of staff available impacted on their care and

support needs.

Although there were a number of systems in place such as auditing to demonstrate oversight of the centre, the inspectors were not assured that these systems were always effective. They had failed to identify the serious issues as found by the inspectors on the day of inspection. For example an IPC audit had been completed in November 2022 indicating high levels of compliance. The findings on inspection did not concur with this and some of the issues identified had been present for a number of months.

Regulation 15: Staffing

The residents in the centre were supported by a combination of nursing care, senior support workers and care support staff. There was a complex system in place in terms of assigning staff hours, with some staff assigned to provide care on a one-to-one basis and other staff assigned to provide support as residents needed it. In addition, staff were assigned to complete social hours only. From speaking with residents and reviewing staff numbers it was found that there was not sufficient staff in place at all times to ensure residents needs were met in a timely manner. For example, only three staff were on duty at night for 13 residents. Residents had complex requirements in terms of their mobility needs and a minimal of two staff were required for turning residents that required this level of care. Residents reported they had wait for periods of time for staff assistance and this was causing distress.

There were planned and actual rosters in place and these were not found to be well maintained. The first and second name of core, relief or agency staff was not always included on rosters, and the role and whether staff were relief or agency was not always identified either.

Judgment: Not compliant

Regulation 16: Training and staff development

A system was in place to track and identify the training needs of the staff team. The inspectors viewed evidence of mandatory and centre specific training records. However, while training was in place, there were a number of staff requiring refresher training in areas such as first aid, positive behavioural support, infection prevention and control specific training and in a small number of the centre specific clinical training programmes such as catheter care. The provider had a plan and scheduled dates in place for outstanding training to be completed in February 2022.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had a management team in place in the centre that comprised a full-time person in charge who was supported in their role by senior support workers and also by a person participating in the management of the centre. The lines of authority and accountability were clear and residents and staff knew who to speak with should they have a concern.

The inspectors found that while there were systems of oversight in place these were not consistently identifying all areas requiring action as outlined throughout this report. Significant risks in terms of fire safety and IPC requirements had failed to be identified effectively. Provider-led and local audits had not identified a number of areas that needed improvement. Although audits had been completed some identified actions had not been completed in a timely manner such as, the repair of a fire door. In addition to this some audits completely failed to identify key areas of improvement, such as IPC audits. The most recent six-monthly provider-lead audit did not review fire safety.

Given the substantive works required to the premises and to ensure that the centre was fire safe the provider, while in discussion with their funder,had not demonstrated a timely or effective system to ensure that the centre was adequately resourced to provide safe care and support.

Residents reported to inspectors that they did not feel that the centre's culture was one that encouraged their feedback on the service provided to them and that the systems of communication were poor.

Judgment: Not compliant

Regulation 31: Notification of incidents

This had been reviewed in advance of the inspection and in part on the day of inspection. The person in charge was aware of their responsibility to submit notifications to the Chief Inspector of Social Services as required by the Regulation. However, a number of notifications were not submitted within the required time frames. In addition some notifications were not meeting the requirements of the definition as set out. This was discussed with the area manager on the day of inspection.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that safe care was not being provided at all times. Immediate actions were issued in relation to fire safety on the day of inspection. Although the provider took some action before the inspectors left the building, additional assurances were sought in writing the following day. In addition to this improvements were required in IPC, premises condition and risk management. The cumulative impact of the non-compliance translated to safe care of residents being compromised.

On the walk around of the premises, a fire door at a kitchen area and a double fire door between a communal area and a hall were observed to be compromised and ineffective. Although the provider had identified the issues with the fire door at the kitchen area, no staff member had knowledge to why the second fire door was ineffective. Fire risk assessments had been completed and fire containment was listed as a key control measure, however, due to the current condition of some fire doors this control measure was no longer in place. As stated previously, residents had significant assessed needs in terms of their mobility and an absence of a key mitigating factors such as adequate fire containment was a very serious safety concern.

During the course of the inspection, the inspectors visited the communal areas of the home, residents individual apartments and apartments that were empty. It was noted that there were significant discrepancies in the presentation of some areas of the home. A number of individual apartments were very clean, individualised and homely. However, some individual apartments were not kept in optimal condition. For example, in one apartment there was a leak, black mould was present and there was a bucket on the floor to catch the drips of water from the ceiling. Due to the size of some of the apartments storage of mops and linen was not in line with best practice in relation to IPC. Some empty apartments were visibly very dirty and had not been cleaned on a regular basis. Residents within this centre had varying clinical care needs and it was essential that IPC requirements were met on a consistent basis. IPC requirements were not in line with best practice on the day of inspection.

Regulation 17: Premises

This centre comprises a large building that contains communal areas and a number of self-contained apartments over two floors. Externally there is a terrace of individual apartments connected to the main building via a covered walkway. The inspectors found that residents apartments were personalised and homely. Each resident pointed out items that had meaning to them and they were comfortable in their home. A number of residents had direct access to small garden or patio areas

and these were areas that were important to them with residents speaking about feeding the birds or sitting out in the summer.

Some apartments required maintenance with areas where paint had chipped or worn or where laminate was chipped off surfaces such as kitchen counters. Bathroom floors in a number of apartments in particular were worn and presented as needing review or replacement. There were worn and broken furnishings in some apartments that required replacement and light shades that needed to be replaced. Some curtains were falling off curtain rails. There was staining on ceilings from previous leaks and there was one ongoing leak in a residents individual apartment.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place and there was a risk register maintained in the centre. The inspectors found that there were risks present in the centre not identified nor assessed, for example, where a light pull cord was considered too short for a resident to reach from bed a plastic bag had been tied to the end of it which posed a serious risk of suffocation. The bag was removed by the inspectors on the day of inspection.

Where other serious risks were present such as the fire containment and fire safety risks these had been assessed as a 'negligible' risk and were set for annual review. There was no evidence that these risks were reviewed when equipment was not operating as required nor when circumstances changed.

Judgment: Not compliant

Regulation 27: Protection against infection

The registered provider had policies and practices in place to protect residents and staff from the risk of infection however, the inspectors found that the centre was not clean and there were significant infection prevention and control concerns. Not all areas of the designated centre were cleaned on a regular basis with some apartments not currently in use or used for respite in particular visibly dirty. In the apartments used for respite stays washing was in the washing machines and it was unclear how long this had been there or whose it was. Used cutlery and crockery was present in sinks and bins had not been emptied. In an empty apartment inspectors found a substantial build-up of dead insects and debris on floors that had not been cleaned.

The inspectors found mould present on the ceiling of one resident's apartment and

there was staining and dirt present in a number of en-suite bathrooms. Cleaning equipment such as mops and buckets were stored wet and not in line with best practice in residents' bathrooms often next to personal care items. Waste bins were not pedal operated in the communal areas of the centre with the main bins outside unable to close as they were overfull. The centre sluice room contained personal care items on open shelving that were dusty and dirty with some urine stained. Additional storage space had been created in what had previously been a visitors bathroom and while the toilet had been removed the floor had not been cleaned and the pipe work was open.

Judgment: Not compliant

Regulation 28: Fire precautions

Under this regulation the provider was required to address an immediate risk that was identified on the day on the inspection. The manner in which the provider responded to the risk did not provide assurance that the risk was adequately addressed. The provider was subsequently issued with an urgent compliance plan the day after the inspection requesting further assurances. The inspectors found that a fire door between a kitchen area and a communal room had a broken closure mechanism and did not close. This had been noted by the staff team on 14 November 2022 and had not been repaired nor any systems to mitigate the risk been put into place. In addition a closure mechanism on one of a set of double doors in place to provide containment between areas of the building was broken. The provider had fixed one door open and blocked the door closure button. This meant that there was no containment between areas of the building. The inspectors ensured that the metal plate that had been fixed to the floor was removed so the one faulty door was shut prior to leaving the centre.

The registered provider had previously committed to completion of identified fire safety concerns by October 2022 as outlined on their compliance plan submitted to the Chief Inspector of Social Services following the previous inspection of the centre. The inspectors found that no actions had been completed and were not scheduled. The provider was in discussion with their funder regarding their ability to complete these works. An external specialist report dated February 2022 had highlighted multiple significant fire safety concerns none of which had been completed despite the provider having committed to same.

Internally within apartments the inspectors found that while fire doors were fitted between bedrooms and kitchen-living rooms there were no self closing mechanisms in place and doors remained open at all times not providing assurance that residents were safe. Residents self reported that they did not participate in fire drills on a regular basis and these were other simulated and not real, the inspectors were not provided with evidence that the minimum number of staffing at night could safely evacuate all residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Waterford Cheshire OSV-0003457

Inspection ID: MON-0030373

Date of inspection: 16/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: New roster has been implemented week commencing 13th February 2023 to ensure staffing establishment will meet Service User Care needs. Care needs analysis and Needs assessment reviewed 18th January 2022 to ensure needs are reflected in new roster. First and second name of core, relief or agency staff is now included on rosters, and the role and whether staff were relief or agency are now being documented also commenced 13th February 2023 Local management will meet Service Users monthly to discuss how roster is meeting their needs and feedback will inform any changes that may need to be made on roster. There will also continue to be Service User meetings monthly. Minutes of meetings are circulated to all Service Users following meeting. Service Users will be encouraged to inform the PIC of their preferred mode of communication around roster and other Service issues. Roster will be fully reviewed 15th May (3 month review after implementation). May 15th 2023.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: First Aid Training held week commencing 30/01/2023. All training will be reviewed quarterly and refresher training will be scheduled as required. Training database now has training scheduled each quarter for staff that are due training and/or refresher training.	

Online training via Cheshire Training academy will be monitored by the PIC to ensure staff keep up to date on training and complete all modules within timeframe. (Now in place).

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The organisation's current audit process is now under review in particular relation to the monitoring and reporting of actions from audits. This action has been agreed by the Quality Safety and Risk Management Board Sub-committee (10/02/2023).

Audit reports will be reviewed by the local management team on receipt of reports and actions assigned to relevant personnel with regular review of action completion.

Audits will be reviewed with relevant personnel so areas identified in recent inspection will be reviewed going forward.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Review of notifications at operational meeting 12/02/2023 highlighted notifications and sending of same not clear and responsibilities unclear.

Process reviewed on 13/02/2023 to ensure going forward notifications are being sent within 3 day timeframe and quarterly reports will be submitted on time each quarter.

Adverse events will be reviewed daily by shift leader to ensure any concerns are followed up immediately and reported accordingly to HIQA if required within timeframe.
There are now clearer delegated persons in the team responsible to support PIC to ensure notifications will be submitted.

For quarterly reports alerts have been created using outlook/teams calendar on laptop by PIC and PPIM as a reminder to submit required notifications on time. Commenced 14/02/2023

PPIM will oversee this going forward and will be informed and cc when each notification submitted.

PPIM will be allocated as super user on HIQA portal.
February 28th 2023.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
30/01/2023 review and tour of premises performed by National Risk Manager and Service Manager to identify works /renovations to be completed

Action plan developed with timelines to complete works identified.

Work has commenced locally for minor repair works by maintenance. Action plan in place and updated when works complete. (completion date for works 30/04/2023).

Outside contractors will be used for painting and ceiling tile replacements. These contractors have already been sourced. (completion date for works 30/04/2023).

Roofer to replace roof tiles to fix leak has submitted quote and will commence work in February. Due for completion March 31/03/2023

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Review of Service by National Risk Manager and action plan developed with timelines

Fire Risk Assessment has been updated to reflect fire works that need to be completed 30/01/2023.

Risk assessment will be reviewed monthly as works progress on schedule of works for fire.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
An Infection Control Audit will be carried out in Waterford Service by the 28th of February by the Regional Clinical Partner with the Service Manager /CNM to ensure they fully understand the process.

Cleaning procedures and schedules in the service have been reviewed and cleaning staff and the local management team updated on the changes made to these.

Regional Manager will review audit of Service on IPC to ensure actions completed within 4 weeks of IPC audit taking place.

While extensive cleaning has taken place and new cleaning procedures are in place in the Service, Contract cleaners will attend the Service to complete a deep clean. To be completed by 31/03/2023.

Areas identified by inspectors during inspection have been included in local premises action plan and equipment and furniture identified have been disposed of.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Schedule of works has been reviewed and funding has been approved by Cheshire Board.

This will be broken down into 3 phases.
Fire Doors have been made a priority have been measured for and ordered.

Etenders have been requested with a timeline of 3 weeks when at this time a contractor to complete these works will be assigned. The 3 phases of works are to be completed by 30th November 2023.

Fire doors in Apt 1 and 17 are doors that were not in original plans and reviewed by housing manager. These have been removed. 14/02/2023.

Fire drills are being undertaken in the service as per our Fire Safety Policy.

Notwithstanding this the service has been instructed to ensure each service user has an individual fire drill completed for both day and night. These are to be completed by 30.03.2023

If a service user refuses this will be documented. A risk assessment will be put in place around any service user that refuses to participate. Where a service user refuses a simulation will take place to determine an approx. time etc. for the evacuation of said SU.

HSE Disability Manager has been informed of these costs so she can inform finance department. This will also be an agenda item on our SLA meetings for 2023.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	13/02/2023
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	28/02/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	30/04/2023

	are of sound construction and kept in a good state of repair externally and internally.			
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	28/02/2023
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.	Not Compliant	Orange	31/03/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of	Not Compliant	Orange	31/03/2023

	healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	17/01/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/03/2023
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	28/02/2023