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:	Cara Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	07 September 2022
Centre ID:	OSV-0003733
Fieldwork ID:	MON-0037007

About the designated centre

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

The designated centre forms part of a campus based service for persons with intellectual disabilities and is located in west Dublin. The centre is comprised of three individual bungalows and provides full time residential services to up to 14 adults. The layout of all three houses is very similar with a spacious entrance hallway, an open plan living and dining area with kitchen space, resident bedrooms, main bathroom and smaller toilet areas. Residents are supported 24 hours a day, seven days a week by a person in charge and a staff team of nurses, carers and house hold staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Wednesday 7 September 2022	09:30hrs to 16:30hrs	Sarah Cronin	Lead
Wednesday 7 September 2022	09:30hrs to 16:30hrs	Marie Byrne	Support

What residents told us and what inspectors observed

This unannounced inspection took place to monitor compliance with the regulations following a poor inspection in March 2022. Due to poor findings a cautionary meeting was held with the provider following that inspection and assurances were sought in a number of areas such as governance and management, risk management and staffing. This inspection found that significant improvements had been made in governance and management arrangements, general welfare development, assessments of need and positive behaviour support. Residents were found to be receiving good quality care, with an increase in opportunities to engage in activities outside their home.

The centre comprises three bungalows beside each other on a campus in West Dublin. Two residents had recently transitioned into the centre from another house on the campus, bringing the total number of residents in the centre to fourteen. Inspectors completed a walk about of all houses with the person in charge and had the opportunity to speak with ten of the fourteen residents and four staff members during the day. One of the inspectors reviewed documentation in one house while the other inspector reviewed documentation in another location. Residents were all well-presented and appeared content and comfortable in the company of staff. A new day service had begun and this included residents going on outings, engaging with day services staff in the house and attending classes or other activities in the day centre on the campus.

All of the houses have a similar layout, with a large open foyer, an open plan sitting and dining room and a modern kitchen. Houses have two accessible bathrooms and five bedrooms. In one of the houses, the fifth bedroom was turned into a sensory room for a resident to use. For the most part, houses were found to be in a good state of repair. Residents had personalised their rooms in line with their interests. There was a lack of storage available in houses, resulting in wheelchairs being stored in the dining room and three shower chairs in one of the bathrooms.

Residents in the centre used a variety of means of communication which included speech, body language, objects, eye contact , vocalisations and behaviour. Many residents required staff to know them well to be able to respond appropriately to specific words they used or to read their body language. Information was available in residents' care plans to guide staff who were less familiar with residents. Inspectors observed residents going about their daily routines such as their personal care routines, mealtimes and attending day services.

Staff told the inspector about the increase in activities for resident and reported that this was having a positive outcome for residents. Staff told the inspector how one resident who had never used public transport before had been on a short train journey which was very significant for them. An incremental approach was taken to ensure that this goal continued to be developed to create more opportunities for the resident. Activities which residents were taking part in were beauty therapy, bingo,

eating out, going to mass , engaging in the day service on the grounds and skills development in house hold chores and activities. While these were very positive developments, staffing levels and lack of consistency was hindering some of the progress with person-centred activities. This was recognised by the provider.

One of the residents spoke with the inspector and told them that they were happy in their home and that the staff were "good" to them. Other residents were observed interacting with staff in all three of the houses. One resident was very vocal at times in the morning and staff were observed to be kind and responsive to minimise the resident's distress. The resident was later observed to be content and comfortable. A meal-time was observed and found to be a calm and relaxed time for residents, with residents sitting around the table together. A photographic menu was used to plan the menu for the week. Food came from a centralised kitchen on the campus. Staff told the inspector that it was possible to accommodate residents outside of set mealtimes with their food preferences. Residents were beginning to develop skills in making smoothies and carrying out house hold chores , which were new experiences for many of them. For all of the residents the inspector met with, they were well presented and appeared comfortable and content. Interactions were noted to be responsive , friendly and kind.

Inspectors viewed feedback from family members, who described the staff as "friendly, welcoming and helpful". Another family stated that they took great comfort in knowing their loved one was happy in their home. Staff turnover was reported to be upsetting for a resident and their family , with the family reporting that trying to make new connections can be difficult.

Residents were consulted with and informed about their care and support and the running of the centre through a number of channels. Weekly meetings took place in each house with the residents and the agenda included menu planning, restrictive practices and activities. Each resident had a monthly meeting with their key workers and made a plan for the month of activities they wished to do. In order to further develop personalised supports, individual preferences and needs assessments were in progress for residents to inform care planning.

Overall, this inspection had positive findings in relation to residents and their care and support needs. Significant improvements had been made in the governance and management arrangements in centre. Improvements were required in staffing, staff training and development and premises. The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The provider had strengthened governance and management systems in the centre since the last inspection. The provider had carried out annual reviews and six

monthly unannounced visits in line with regulatory requirements.At provider level, there were regular governance meetings with members of the senior management team , quality and risk officers and members of the local management team. A detailed residential improvement plan had been developed and actions were in progress. The person in charge and person participating in management collated data from audits each month, trended incidents and presented regularly on their progress with actions from audits, inspections and annual and six-monthly reviews. At centre level, the person in charge demonstrated increased monitoring, oversight and operational management of the centre which improved the quality and safety of care of the residents. For example, all residents had an assessment of need carried out to inform staffing levels and to form a business case. There was a clear schedule in place for audits and who was responsible for carrying these out. These audits and reports demonstrated that the provider was self-identifying areas for improvement. Key performance indicators had been developed for members of the management team as an additional quality assurance measure.

The provider had appointed a suitably qualified and experienced person in charge. They were supernumerary and worked full-time in the centre. They had put a number of effective management systems in place to ensure that plans were actioned and to ensure that they had good oversight of all aspects of the residents' care in the centre. Inspectors found the person in charge was very familiar with residents and their assessed needs.

Since the last inspection, the staffing levels in the centre had been increased to ensure that all residents' support needs were met at all times of the day. Assessments of need and dependency levels of all residents had been carried out and used to inform a business case to the senior management team on proposed staffing levels. However, staff shortages in the centre remained, with 5.5 whole time equivalent posts vacant on the day of the inspection. The provider had made significant efforts to recruit staff, with small success. The sample of rosters viewed indicated that while all shifts were filled, these were done by a large number of agency staff. This had a negative impact on continuity of care and the ability to fulfill some residents' social and recreational goals. Inspectors carried out a review of staff files and found these met regulatory requirements.

Staff training and supervision had improved since the last inspection, with all staff now in receipt of supervision from the person in charge. The person in charge met with their manager monthly. There were notable improvements in the number of staff completing training and refresher training, with some small gaps remaining in areas such as fire safety, safeguarding, hand hygiene, first aid and positive behaviour support. However, these sessions were all booked for the weeks following the inspection.

Regulation 14: Persons in charge

The provider appointed a suitably qualified and experienced person in charge. They

had a good knowledge of all of the residents and their needs. Evidence viewed throughout the day indicated that the person in charge had effective management systems in place to ensure monitoring and oversight of the centre in addition to ensuring that all residents were in receipt of good quality care.

Judgment: Compliant

Regulation 15: Staffing

Staffing remained an area of concern in the centre. Since the last inspection, the staffing complement had increased by two staff each day in order to meet the personal care and support needs of residents. An assessment of need had been completed for each resident and these results were collated to inform a proposal for the recommended staffing levels and requirements. The provider had made significant efforts to recruit staff, with some success. However, there was 5.5 whole time equivalent (WTE) posts vacant on the day of the inspection

Planned and actual rosters were well maintained and indicated that while shifts were being filled, there was a high number of different agency staff completing shifts. For example, one one week, there were 21 shifts covered by 11 different agency staff members , while on another planned roster, there were 38 shifts which required 9 agency staff. Staff whom the inspectors spoke with reported that while having additional staff was of enormous benefit, it was difficult at times to induct and handover to unfamiliar staff, particularly for residents who had complex support needs. In addition to this, residents were not experiencing continuity of care. The provider recognised this risk and had a risk assessment in place and control measures to attempt to have consistent agency staff working in houses to reduce the impact on residents.

A sample of staff files were viewed by the inspector and these had all the information required by Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

A training needs analysis had been completed by the person in charge since the last inspection. Training records were viewed and indicated that for the most part, staff had completed mandatory training in areas such as fire safety , safeguarding, manual handling and food safety. Additional training had been undertaken in areas identified as relevant to the residents' needs on the last inspection such as Autism, positive behaviour support and managing feeding, eating, drinking and swallowing difficulties. Where training was required, it was scheduled for the weeks following

inspection. A sample of staff supervision sessions was viewed by an inspector. These showed that supervision was structured and supportive and included relevant agenda items to the centre such as safeguarding, risk, documentation and infection prevention and control.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors observed significant improvements in governance and management arrangements since the last inspection. Annual and six monthly unannounced visits had been carried out in line with regulatory requirements. Actions arising from six monthly unannounced visit, the annual review and the last inspection were all tracked and under regular review. Most of the actions had been completed or were in progress. Regular governance meetings were taking place between local and senior management, which included review of all actions and progress on the provider's residential improvement plan. Key performance indicators had been developed for members of the management team as an additional quality assurance measure. At centre level, the person in charge demonstrated increased monitoring, oversight and operational management of the centre which improved the quality and safety of care of the residents. For example, all residents had an assessment of need carried out, incidents, risks, safeguarding were all centralised and logged. There was a clear schedule in place for audits and who was responsible for carrying these out.

The person in charge and the person participating in management met once a month and reviewed audits and required actions. Persons participating in management now visited each house at least monthly and quality walkabouts had taken place by the Executive management team. Staff meetings occured once a month and included all staff including persons participating in management. The agenda for these meetings had standing items such as residents meetings, risk, health and safety, incidents trending and learning, safeguarding and infection prevention and control. There were suitable arrangements in place to monitor and manage the performance of staff.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose for the designated centre which met regulatory requirements.

Judgment: Compliant

Quality and safety

Residents in the centre were noted to receive good quality care and they were experiencing a better quality of life due to an increase in activities and participation in life outside of the campus. All residents had a comprehensive assessment of need carried out and individual preferences and needs assessments were in the process of being completed. The provider was tracking activities which residents were engaging in on a monthly basis and these demonstrated a significant increase on the number of opportunities residents had to engage in social activities each month. Staff were in the process of developing more meaningful person-centred plans and to identify new experiences for residents each month. The provider had a plan in place to continue to up skill staff in developing and delivering on person-centred plans. Documentation in care plans had also improved. A sample of files viewed indicated that all of these care plans had been updated since the last inspection and that they contained relevant, up-to-date information only.

As described earlier, the centre is made up of three houses on a campus. Houses were clean , warm and well-suited to the residents' needs. Storage was noted to be a significant issue in the houses. At the entrance to each house, there was a large foyer, with personal protective equipment (PPE), oxygen cylinders and other equipment. There was not adequate storage space for wheelchairs and shower chairs in one of the houses. In another, there were a number of files on a trolley in a sitting room which were in the process of being archived.

Risk management systems were strengthened and ensured that all risks in the centre were identified, assessed and reviewed regularly. The person in charge had developed a central risk register to ensure that the risks for each house were collated which enabled better oversight. Adverse events were found to be documented and reported in line with the provider's policy and these events were analysed regularly to identify trends. Any learning from events was shared as a standing agenda item at staff meetings.

For residents who required positive behaviour support, plans were now clear and had information to guide staff on creating low arousal environments and resident-specific proactive and reactive strategies to use. There was evidence of these plans being reviewed and updated in response to any incidents. Restrictive practices were regularly reviewed and there was evidence to indicate that the impact of restrictions on other residents living in the house was considered using a rights-based approach, with plans in place to develop skills to reduce this impact.

Residents were found to be safeguarded from all forms of abuse. Oversight of safeguarding incidents had improved, with a central log of incidents kept. Any safeguarding incidents which had occured were documented, reported and investigated in line with national policy. Safeguarding was a standing agenda item at

all staff meetings and in staff supervision sessions. A sample of personal and intimate care plans were viewed and found to have clear information for staff on seeking residents' consent to carry out care and on the exact care and support each person needed in different aspects of their personal care.

The provider had a human rights officer who had carried out an assessment of each residents' rights in conjunction with residents and the multidisciplinary team. Rights assessed included the right to privacy, safety, freedom of choice, personal possessions and the impact of any restrictive practices on each resident. Risk assessments had been developed on rights infringements where they were required. Residents meetings took place in each house on a weekly basis and standing agenda items included menu planning, house-related business and planning activities. In each of the houses, inspectors observed staff to be responsive and respectful to residents and supported them to make choices in their day.

Regulation 13: General welfare and development

As outlined above, residents were found to be engaging in more activities both on the campus and off the campus since the last inspection. The inspector viewed plans and photographic evidence of residents being supported to learn skills such as using their swipe card to enter their home, doing household tasks such as laundry and experiencing making smoothies.

Residents had a 'quality of life' section in their care plan. A monthly audit was taking place which ensured oversight of the activities and the outcomes experienced by residents taking part in these activities. Key workers met on a monthly basis to review monthly activities and to plan for the month ahead. Activity trackers indicated a steady increase of residents' opportunities to engage in activities each month since the last inspection. For example, 29 outings took place in April , while 73 outings had taken place in June. Residents were supported to maintain contact with their family members and those important to them.

However, staffing levels and the availability of regular staff hindered residents' opportunities for activation and meaningful engagement at times. Further work on individual needs and preferences assessments was required to ensure residents continued to be offered supports and opportunities in line with their expressed will and preferences.

Judgment: Substantially compliant

Regulation 17: Premises

All of the houses were of a similar layout, with a large foyer, an open plan sitting room leading to a dining and kitchen area. Residents were able to access a small

garden space through sliding doors. For the most part, the houses were in good condition and nicely decorated throughout. There were ample bathing and toileting facilities and residents had personalised their bedrooms. There was maintenance work required in one of the bathroom floors, some paintwork was scuffed and there were some holes in the walls due to mobility bars being removed. These had been identified by the provider and a plan was in place to carry out these works.

Storage was a significant issue and had an impact on the homeliness of some of the houses. In the foyers of each house, there were cupboards used for files, oxygen, personal protective equipment and other items. In one of the dining rooms, there were three large wheelchairs stored there while in one of the bathrooms there were two commodes and a shower chair. One of the living rooms had a trolley with files on it and a small desk. These were due to be archived. All of the houses had external laundry and 2 had sheds for donning and doffing of personal protective equipment. There were no offices available for staff to use and there were work stations in each bungalow on the corridor.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management systems had improved since the last inspection. Risks were found to be identified, assessed and reviewed regularly. There was a clear system of oversight in place, with a central risk register held by the person in charge. Adverse incidents were found to be documented and reported in line with the provider's policy. The provider had developed a tool for staff to use following incidents to ensure appropriate follow up took place, which included updating risk assessments where this was required. Incidents and accidents were reviewed on a monthly basis and learning was shared with the staff team.

Judgment: Compliant

Regulation 28: Fire precautions

The provider was found to have effective fire safety management systems in place. Detection and containment measures, fire- fighting equipment and emergency lighting were in each of the houses. Regular testing of equipment took place. Equipment was serviced regularly. Staff had received training in fire prevention in addition to training on the use of specific evacuation aids such as the albac mat. Drills were occurring regularly and oversight of these drills had increased to ensure that all staff members were regularly taking part in drills and that learning was identified and communicated with the staff team where required.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Since the last inspection, every resident in the centre had an assessment of need which was used to inform required staffing levels and care plans. An individual needs and preference assessment was in progress for residents and due to be completed by the end of September 2022. These assessments were to be used to inform residents' person-centred-plans and daily activities. The inspector viewed a sample of five care plans and found that they had been updated and improved to ensure up-to-date, relevant information was present to guide staff.

Person-centred plans were in the process of being developed on the day of the inspection. The provider had a plan in place to continue to develop staff skills in developing person-centred-plans which reflected each residents will and preference in relation to activities and social engagement.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents with positive behavioural support needs had access to relevant professionals such as a clinical nurse specialist in behaviour, a psychiatrist and other multidisciplinary team members as required. A sample of positive behaviour support plans were found to have clear information on creating a low arousal environment and pro-active and reactive strategies for staff to use with different residents. There was evidence of these plans being updated following incidents in the centre to ensure they remained relevant and up-to-date. There were environmental and physical restrictions in place in the centre which were largely for health and safety reasons. For example, lap straps on wheelchairs and most external doors were accessible by swipe only. There was evidence that these restrictions were regularly reviewed and that residents were being taught how to use their own swipes where appropriate to reduce the impact of locked doors on their freedom of movement.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place to protect residents from all forms of abuse. There had been a small number of safeguarding incidents in the centre which had been documented, reported and investigated in line with national policy.

Safeguarding plans were put in place for residents who required them with input from the multidisciplinary team. The person in charge had oversight of all safeguarding incidents and the status of these incidents in the centre. A sample of intimate care plans was reviewed and these were found to be detailed and gave clear guidance on the exact level of support which residents required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had had a human rights assessment carried out by the human rights officer with input from the multidisciplinary team which included a review of the residents' personal possessions, their home, finances and their freedom of movement. Consideration was given to the will and preference of residents in relation to restrictions that were in place and there were risk assessments on any rights infringements identified.

There was evidence of staff being responsive to residents' communication throughout the day. Residents were noted to be consulted with about various aspects of their lives and in the running of their centre. Easy-to-read information was available in the house about different health conditions and advocacy supports. Visual supports were available to aid understanding of menu planning and restrictive practices.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cara Residential Service OSV-0003733

Inspection ID: MON-0037007

Date of inspection: 07/09/2022

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Since inspection; 2.0 x wte Staff Nurses commenced in the centre in August 2022 to support continuity and quality of care 0.77 x wte Staff Nurse commenced in October 2022 2.0 x wte Staff Nurses(Pre Registered Nurses) to commence November 1st and 3rd , 2022. Treshold for nurses has increased by 2.0 wte for nurses. 2.0 x wte Care Staff are in post in the centre since September 2022. 1.0 x wte Care Staff is in recruitment and awaiting a start date. 1 x Care Staff by night has commenced. The care staff threshold has increased by 2.0 wte for the centre. Staffing review has been completed.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Outstanding staff training has been identified and scheduled for completion by 31/12/22.	

Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: Permanent Staffing levels have increased from the day of inspection by 2.0 x wte Staff Nurse and by 2.0 x wte Care Staff for the centre. This will enhance the availability of regular staff to support residents in opportunities for activation and meaningful engagement. In addition 15 hours per week has been allocated to the centre from Day Service to further support and enhance quality of life for residents. An Individual Preferences and Needs Assessment has been completed for each resident which will ensure residents are offered supports and opportunities in line with their individual expressed will and preference .	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A review of the storage requirements and office space will be implemented and a plan of action will be implemented thereafter. A review of the centre's filing has been completed and will ensure that records are archived off site on a monthly basis.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/01/2023
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	28/02/2023
Regulation 15(3)	The registered provider shall ensure that residents receive	Not Compliant	Orange	28/02/2023

	continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
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	31/12/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2022