Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St. Brendan's High Support Unit
Name of provider:	Mulranny Day Centre Housing Limited
Address of centre:	Mulranny, Westport, Mayo
Type of inspection:	Unannounced
Date of inspection:	18 January 2022
Centre ID:	OSV-0000389
Fieldwork ID:	MON-0035680

About the designated centre

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

St. Brendan's High Support Unit is a purpose-built facility which can accommodate a maximum of 33 residents. It provides care to dependent persons aged 18 years and over who require long-term residential care or who require short term respite, convalescence, dementia or palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. This centre is situated in the village of Mulranny on the N59 Newport to Achill road and just off the Great Western Greenway. It is part of a supported housing complex and day care service operated by Mulranny Day Centre Housing Limited. The building is split level over two floors with lift access to the upper floor. Bedroom accommodation for residents is available on both floors and consists of single and double rooms. A variety of communal space is available for residents to use during the day and includes two sitting rooms, a dining area, an oratory and visitors' room. The centre is set in spacious grounds and overlooks the sea.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	28

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 18 January 2022	09:30hrs to 16:00hrs	Catherine Sweeney	Lead
Tuesday 18 January 2022	09:30hrs to 16:00hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

The centre was experiencing an outbreak of COVID-19 at the time of the inspection with necessary restrictions impacting on the day-to-day lived experience of residents. Inspectors were sensitive to this situation at all times during the inspection. Throughout the day of this inspection inspectors spoke with a small number residents and observed staff interactions with them. Inspectors observed that staff were responsive to residents needs. All interaction observed between staff and residents was kind and respectful. In spite of the current outbreak and staff being very busy inspectors noted that the atmosphere was calm and that nurse call bells were responded to in a timely manner. Residents themselves appeared calm and comfortable.

The centre comprises of both single and twin rooms. Residents were not allocated to specific positive or not-detected areas of the centre, but were isolating in their own rooms or for those residents in the twin rooms, isolating with fellow residents who also had a positive diagnosis of COVID-19. Most residents spent their day isolating in their bedrooms however, a number of residents with complex behaviours and who were not able to comply with the isolation restrictions were mobilising around the centre under the supervision of the care staff. Staff had interventions in place to restrict the movements of these residents in an appropriate and respectful manner, however, the movement of these residents outside of their bedrooms increased the potential risk to those residents and staff who had not contracted COVID-19.

The centre was organised into three wings, the east, west and north wing. Due to the number of residents and staff who had tested positive it was not possible to cohort the positive residents into one area of the centre. This meant that precautions were required to ensure that adequate infection and prevention controls were in place to protect the eight residents who, at the time of the inspection, had remained 'not-detected'. The COVID-19 status of each resident was documented in the electronic nursing documentation system and staff working in the centre were aware of the COVID-19 status of each resident. However, some residents had been moved out of their twin rooms into single room accommodation. There was no communication system in place to ensure that all staff including agency, HSE support staff or essential support workers could easily identify each resident and be aware of their COVID-19 status.

The provider had a contingency plan in place to ensure hot meals were available to the residents throughout the outbreak period. An arrangement was in place with a local hotel to provide hot meals to residents. Meals were observed to be appetising and nutritious.

A member of staff was allocated to supporting the social care of residents while they were restricted to their bedrooms. One-to-one activities were facilitated and all residents were supported with social engagement throughout the day of the inspection. National and local newspapers were available and residents also had

access to television and radio in their bedrooms.

The next two sections of this report will summarise the findings of the inspection and discuss the levels of compliance found under each regulation.

Capacity and capability

This was a one day unannounced risk inspection by inspectors of social services triggered in response to:

- an outbreak of COVID-19 in the centre
- the absence of a person in charge in the centre

The lead inspector was supported by an infection prevention and control inspector.

The Chief Inspector was notified of a COVID-19 outbreak in the centre on the 11 January 2022. On the day of the inspection 20 residents and 11 staff had a positive diagnosis of COVID-19.

The provider of this centre is Mulranny Day Centre Housing Limited. The board of the company consists of nine voluntary directors. The company chairperson is the registered provider representative and they have a strong presence in the centre.

The organisational structure within the designated centre, committed to in the statement of purpose, is no longer in place. There was no person in charge of the centre on the day of the inspection. The previous person in charge had left their post in December 2021. The provider confirmed that a new person in charge had been recruited and was due to commence in early February 2022.There was a plan in place to ensure interim management arrangements were maintained in the absence of a Person in Charge, however the plan was not effective which resulted in a lack of effective leadership and nursing oversight in the centre during the COVID-19 outbreak.

Prior to the COVID-19 outbreak, the centre was inspected in July 2021 where a number of non-compliance's were found including governance and management, staffing, premises and fire safety. Following the July inspection, inspectors of social services had significant engagement with the provider to ensure that the non-compliance's would be addressed to ensure that residents received a safe service which was effectively monitored.

This inspection focused on the care and welfare of residents in the centre during the COVID-19 outbreak. The findings of this inspection were that resident's basic social and health care needs were met on the day of the inspection. However, due to poor information management, it was difficult to assess if the provider had adequate staff available to meet the needs residents in the days following the inspection. Furthermore, inspectors were not assured that the systems of record keeping were

adequate to ensure that care was recorded in a way would allow nursing and care staff, who may not be familiar with the needs of the residents, to provide consistent and safe care.

Staffing on the day of the inspection was not reflective of the centres normal roster, however staffing levels were observed to be adequate. There was one nurse on duty who was supported by both a clinical nurse manager, who attended the centre at different times during the day, and the provider representative. The provider representative was also the general practitioner (GP) for the designated centre and was on site throughout most of the day of the inspection providing medical oversight for the residents. A team of up to eight carers facilitated the care of the residents. Meals had been out-sourced to a local hotel, allowing staff to be redeployed from catering duties to the delivery of care. These members of staff had previous experience in the delivery of care. In addition, support staff included an administrator and a team of three cleaners. The deployment of staff on the day was in line with the centre's COVID-19 contingency plan. Staff spoken with demonstrated a good knowledge of the needs and preferences of each resident and could describe both the typical and atypical symptoms of COVID-19 infection. Care staff were clear on how to report any changes in relation to a resident's condition to the nurse in charge.

The Health Service Executive (HSE) Outbreak Crisis team was supporting the centre through the outbreak. The provider and senior nurses were in daily communication with this team. Inspectors found that improvement was required in relation to how information, in particular the staffing requirements for the centre, was communicated to external agencies supporting the centre during the outbreak. For example, although there was a COVID-19 line-listing record of all staff with details of the date staff were tested or had developed symptoms, and the result of their test, this line-listing did not tally with the staffing roster on the day for which staff were on duty and which staff were on COVID-19 absence.

There were six nurses employed in the centre, however, only two nurses were available to work. The roster had not been updated with a record of staff that were not available for work or the staff that had been sourced for the centre by the HSE outbreak crisis team. This meant that it was very difficult to determine the staffing requirements for the centre. Accepting that staffing availability was changing hourly in light of COVID-19 test results being received, inspectors were not assured that there was a person responsible for collecting this information and updating the staff roster so that staff vacancies could be identified in a timely manner and communicated clearly to the external agencies supporting the centre.

The centre had been supported by staff from the HSE on the days preceding the inspection and there was a clear expectation that further external support would be required to ensure the centre was safely staffed during this outbreak. In light of this, inspectors reviewed the nursing documentation of a sample of residents to ensure that the system provided a clear and effective account of each resident’s baseline health care needs and a record of all observations and interventions completed to monitor and care of the residents.

Inspectors found that observations of each resident's vital signs were not documented consistently in the same format. This meant that it was difficult to assess changes, both improvement and deterioration, in a residents condition. For example, a resident's oxygen saturation level was recorded on paper by some nurses and on the electronic documentation system by other nurses. As a result it was difficult to monitor and assess the overall progress of a resident.

The system of administering medications in the centre included the storage of each resident's medicine in an individual locked cabinet beside their bed. However, some residents had been transferred from twin to single rooms to facilitate infection control interventions and inspectors found that their medication was not transferred with them. The management team had failed to recognise the risk that this posed to residents in the event that a nurse, who may be unfamiliar with the residents and the medication management system, would not be able to locate and administer the correct medicines for each resident.

Regulation 14: Persons in charge

There was no person in charge in the centre as required under Regulation 14.

Judgment: Not compliant

Regulation 15: Staffing

While staffing levels were adequate to meet the needs of the residents, on the day of the inspection inspectors were not assured current staffing levels could be maintained if more staff were required to go off duty with detected or suspected COVID--19.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of the training records found that staff had completed training in Infection prevention and control. However, training records did not specify the content of the training nor the percentage of staff who had attended. Records shown to the Inspector indicated that training had been completed in 2020 with no up-to-date training in 2021.

Judgment: Substantially compliant

Regulation 21: Records

A review of the nursing documentation system found that nursing records for each resident did not contain a record of each residents health, condition and treatment given, as required under Schedule 3. The nursing daily progress notes did not give a clear description of the daily status of the resident making it difficult to track each resident's progress and detect changes in their health status in a timely manner.

In addition, the roster was not kept up to date and did not facilitate effective identification of staffing requirements which resulted in incorrect information being submitted to the HSE Outbreak Crisis Team and impacted on their availability to respond in a timely manner.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management of the centre was impacted by the lack of a person in charge to coordinate staffing, information governance and overall management of a COVID-19 outbreak. The nominated persons identified in the centres COVID-19 contingency plan to manage any outbreak, were no longer employed in the centre.

Inspectors acknowledged that the provider representative and the clinical nurse manager were actively engaged in the oversight, management and delivery of residents direct care and worked tirelessly to ensure that residents were cared for and felt safe during the outbreak. However, the lack of robust governance and management processes resulted in poor infection control practices and impacted on the management of staff and the management of important information.

Poor risk management was found in relation to the medication management system in place.

Judgment: Not compliant

Quality and safety

Overall, the findings of this inspection was that resident were receiving appropriate

levels of care. Direct personal care, the provision of social care, and communication with residents and their families, including visiting arrangements, were found to be of an appropriate standard. Improvements were found to be required in infection prevention and control procedures.

Regulation 11: Visits

Visiting to the centre was restricted due to the COVID-19 outbreak. However, inspectors observed that visiting was facilitated on compassionate grounds, in line with the Health Protection Surveillance Centre (HPSC) National guidelines.

Judgment: Compliant

Regulation 27: Infection control

Inspectors identified inconsistencies in applying standard and transmission-based precautions as per "HIQA National Standards for infection prevention and control in community services" Standard 2.1. As a result, efforts to prevent and control COVID-19 transmission were restricted. For example;

- There was no identified person or persons with appropriate knowledge and skills to manage key areas of infection prevention and control within the centre. The HSE Infection Prevention and Control (IPC) nurse had attended to support the outbreak on the 16 January 2022 but the centre did not have access to person or persons with appropriate knowledge and skills to manage key areas of infection prevention and control within the centre.
- The nurse on duty was caring for both residents with confirmed COVID-19 and residents in whom COVID-19 had not been detected.
- Separate dining and changing facilities were not available for staff allocated to care for residents with COVID-19 and for those whom did not.
- Staff were donning and doffing full personal protective equipment (PPE) each time they entered and entered rooms and on occasions staff were seen not removing PPE in-between rooms.
- PPE stations were haphazard and contained more equipment than was necessary which increased the risk of meant potential cross contamination.

There were insufficient local assurance mechanisms in place to ensure that the environment and equipment was decontaminated and maintained to minimise the risk of transmitting a health care-associated infection as outlined in National standard 2.2 and 2.3 For example:

- Improvements were required in equipment and centre hygiene. Staining and

rust was observed on a shower chair in the assisted bathroom. Several hoist slings were found hanging of pieces of equipment and no resident identifiers were seen on the slings, indicating they were not resident specific. Wheelchairs and cushions were seen stained and dusty. Damaged, worn and torn chairs, cushions, mattresses were seen which inhibited cleaning for these items.

- Many items of equipment and boxes were seen stored on floors which is inappropriate and unsafe as cleaning the floor beneath is impossible and the items become contaminated.
- The housekeeping trolleys were not allocated to COVID-19 areas and non-COVID-19 areas, thus, running the risk of cross contamination during cleaning.
- The correct chlorine bleach product was in place for disinfection but an incorrect dilution rate was used. The product was not being used within manufacturers guidelines.
- The cleaners room was situated in an outside shed. Inspectors found that this shed was unlocked and contained inappropriate storage of chemicals. There was also no access to janitorial or hand washing facilities. The shed was found to be used to store resident equipment. This area was also used to store items for disposal, including used mattress.
- There was no compliant hand wash sink available in the resident wings.
- The dirty utility room contained a bedpan washer that had a display but did not indicate what temperature was reached during the disinfectant cycle, records were requested regarding service history but none were seen.
- Two spill kits in the dirty utility room contained two out of date chlorine disinfectant tablets tubs and the buckets were wet from leakage from a spray bottle of an unknown substance.

The inspector identified inconsistencies in identifying and managing outbreaks as per standard 3.4 For example:

- There was a COVID-19 Contingency Plan in place but unfortunately key personal mentioned within the plan had since left the centre which left the centre without a qualified Person in Charge and deputy.
- Extensive wear of PPE in non-COVID-19 areas could have escalated outbreak due to staff not wearing and changing correctly.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the resident files found that each resident had a comprehensive assessment and care plan in place as required under Regulation 5.

Judgment: Compliant

Regulation 6: Health care

A review of the nursing documentation and the care delivery observed provided assurance that the health care needs of each resident were met during this outbreak of COVID-19. Clinical oversight was proved by the provider representative who was a general practitioner with support from a consultant geriatrician.

Judgment: Compliant

Regulation 9: Residents' rights

There were systems in place to address the risk of social isolation as a result of the COVID-19 restrictions in place. Care staff were specifically allocated to social care and residents were provided with activities, newspapers, radio and television while movement around the centre was restricted.

Staff had informed residents of the current outbreak situation in the centre. A review of the residents notes found that the provider had communicated with the families of residents to provide updated and reassurances.

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. Brendan's High Support Unit OSV-0000389

Inspection ID: MON-0035680

Date of inspection: 18/01/2022

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A DON/PIC was appointed and in post on February 7th 2021. • One Clinical Nurse has commenced a Management Course (11/02/22) in the absence of a ADON. • The Clinical Nurse deputizes in the absence of the DON. • On call rota active for weekends.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: ***The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.*** The Home has • 4x staff with multi task attendance rosted at 12hrs per week when required. • Two health care assistant staff have been employed • A recruitment agency is actively recruiting for the home Contingency plan for emergency staffing if required in a crisis • Increase the HCA hours of the 4x multi task attendance staff on a short term basis to cover the crisis period • Request staff through a Staffing Agency (used during covid).	

• Request staff through a recruitment agency. • DON to cover nursing tasks short term where required.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

• Evidence of training and certificates requested for all training completed

• Admin to collect and place in personnel folders and complete the training stats report for the HIQA folder weekly.

• All new staff have a time frame to complete mandatory training/online training of 6 weeks and up to 12 weeks .

• Training and development is ongoing and staff will have the opportunity to discuss this at the staff meeting on Wednesday 16th February to ensure training is achievable and delivered adequately.

• Staff will be issued with training plans and realistic time lines to complete.

• Fire training and Fire evacuation in particular are up to date.

• Mandatory is ongoing. Next evacuation training planned for 14/02/22

• Management training for the Clinical Nurse has commenced.

• Venepuncture for nurses 17/02/22

• Infection Control Course sourced for 2x named IC Leads newly appointed.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

• HIQA folder created in the office with the basic outline of required information available for inspections
• Nurses and admin to update stats in the folder on a weekly basis.(Rotas/training/etc)
• Sub folders to be available in the Office so all key staff can obtain the information easily
• Nurses trained to use a new electronic record system (23/02/21) so can demonstrate any quality assurance required

• Agency staff were employed during the Covid outbreak
• A Best Practice document is being drawn up for the nursing staff to assist with correct documentation and this can be handed to agency staff as a step by step of simple instructions and professional expectations to ensure each staff member on shift is reliable and safe and Residents notes are correctly documented in the correct place. This document will be complete by Monday 21/02/22

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.
• DON /PIC appointed and in post since February 7th 2022
• Clinical Nurse receiving Management Training through an approved provider 11/02/22
• On call rota established for any out of hour gaps.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Staff Meeting Planned for Wednesday 16th February 2022

• Post Covid discussions to be held with staff. Try to identify "What we did well" and "What we did not do well"
• Verification that all staff have completed their HSEland Infection Control Module and can discuss the outcomes and learnings.
• To confirm that all staff understand the infection control procedure and have read the

policy.
• Correct wearing of masks and PPE to be discussed and demonstrated if required. When donning and doffing is required as there was some confusion noted that doffing was not required when caring for several positive Residents in the same area i.e two adjacent rooms.
• DON to oversee the IC measures in place currently, as no IC lead. DON to give an overview of cross infection risks and risk management to all staff.
• IC lead to be appointed with a relevant course/updated training and capacity to train staff informally on a day to day basis.
• New slings arrived 04/02/2022 and correctly distributed to individual Residents. Slings marked with Residents names. Old slings disposed of.
• Equipment review – 09/02/2022 – all rusty equipment removed if damaged or unsuitable.
• General clearing of the PPE store completed 14/02/2022 with all boxes lifted above ground level as per best practice.
• Central stores reviewed for de-clutter and out of date or unused items removed.

Staff
• To change their uniforms in the newly appointed staff house locker rooms.
• Staff meals to be taken in the new staff house ONLY once the flooring is completed; expected by the 18/02/2022 (Currently staff should not take breaks or meals when residents are present to minimize cross infection)
• Staff uniforms to be worn correctly according to the Uniform policy. No cardigans or below elbow clothing during care, to allow for thorough hand washing.
• Additional hand washing facilities under review. Sanitizer stations insitu.
Chemical Agents
• Staff to review the "Safety, health and Welfare at Work (Chemical agents)(Amendment) regulations 2021
• Meeting with Cleaning Supervisor 11/02/2022 to discuss the products and ratio and to conduct a
1. General supervision with her staff re products and dilution and sign this off (Supervisor will complete this over 1 week with all her staff. (14/18th Feb 22)
2. Safer handling of products update
3. Storage and security review with all staff
4. Utility room cleanliness checklist. (11/02/22)
5. Regular spill kit check implemented and to be signed off weekly by Cleaning Supervisor. (14/02/22)

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 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	07/02/2022
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	28/02/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	14/02/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available	Not Compliant	Orange	14/02/2022

	for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	14/02/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	28/02/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	28/02/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	07/02/2022
Regulation 27	The registered provider shall	Not Compliant	Orange	16/02/2022

	ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			