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

Issued by the Chief Inspector

Name of designated centre:	Ash Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Roscommon
Type of inspection:	Unannounced
Date of inspection:	08 June 2023
Centre ID:	OSV-0004695
Fieldwork ID:	MON-0035506

About the designated centre

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

Ash service is a full time residential service that supports up to seven adults with an intellectual disability, some of whom are on the autistic spectrum and who may present with behaviours that challenge and mental health issues. Individual day service programs or wrap-around services have been developed for residents in recent months. Ash services is made up of three houses; the residents residing in these houses receive varying levels of support, depending on their needs, from a team of social care workers and support workers. The houses are located in community settings in Co Roscommon, all residents have their own bedrooms and there is sufficient communal space for residents to entertain visitors and have privacy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Thursday 8 June 2023	09:30hrs to 15:30hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

The inspector had limited opportunity to meet residents due to their day activities and planned events, which included day services and some residents attending individualised programmes, however two residents called to meet and speak with the inspector before they headed off with their staff. Both residents were smiling and engaging in a positive manner with staff and the inspector. Both residents shook hands and chatted about their day and how well they were supported in the centre. The inspector also observed the ease that both residents interacted with staff and that one resident sought reassurance about days staff were working, which staff provided and reassured this resident calmly, putting them at ease.

From speaking with the person in charge and staff it was clear that many measures were in place to care and support residents as per their assessed needs while also ensuring that they benefited from a quality of life. It was also evident that the person in charge and staff helped the residents on a daily basis to understand and manage their schedule effectively, through a person centred approach and with the use of communication tools available in the centre, which included photos, gestures and objects of reference. Residents attended weekly meetings to discuss and plan their events and gather their views on the centre and everyday life, which reflected their choices and preferences. Staff engaged with residents in a warmly and comfortable manner throughout the inspection. The inspector also noted that from observation of the interaction between staff and residents, the residents were very clear on their choices and preferences at all times. There was evidence that residents were out and about in the community and involved in activities that they enjoyed and found meaningful. Leisure activities that residents enjoyed and took part in, included cinema, shopping, family involvement and outings to local restaurants and places of interest. Residents had the option of receiving a home based service from the centre, or to attend day services in the local area.

This centre comprised of three houses which was located on the outskirts of a small town in Roscommon and had good access to a wide range of facilities and amenities. The centre had three houses which were located in close proximity to each other and each house had a well-equipped kitchen and dining area, an office and staff sleepover facility, and laundry facilities. All residents had their own bedroom with adequate access to bathroom facilities. The inspector noted that each house was very personalised and reflected the residents choice, preferences and activities they enjoyed. However, the inspector noted that while there were actions outstanding form the inspection completed in 2021 and additional works were now required.

Overall, it was evident from observation in the centre, conversations with staff and information viewed during the inspection, that residents had choices in their daily life, and were supported by staff to be involved in activities that they enjoyed, both in the centre and in the local community. Throughout the inspection it was clear that the person in charge and staff prioritised the wellbeing and quality of life for the

residents. However, areas of improvement were required which were outstanding from the previous inspection in 2021, this included works required throughout the houses, the oversight of this service through governance and management, the statement of purpose, risk management and staffing, which will further be discussed in the next two sections of the report.

Capacity and capability

There were robust management arrangements in place which ensured that there was a good level of compliance with regulations, and that a good quality and safe service was provided for the resident who lived in this centre. However there were areas for improvement which included addressing areas for improvement within specified timebound plans, such as premises works, staffing requirements in line with the statement of purpose and the statement of purpose.

Audits were being carried out by the person in charge and staff to review the quality and safety of the service. A monthly audit plan for 2023 had been developed and specific audits were identified to be carried out each month. These included audits of fire safety, finances, health and safety, medication, infection control compliance, and restrictive practice The required audits had been completed to date. The provider was aware of the requirement to completed unannounced audits on behalf of the provider twice each year, and these processes were in place and completed. Two unannounced audits had taken place in 2022 and 2023, and the provider had identified areas of good practice and areas for improvement, such as activity sampling. The annual review of the service was completed and due for an update this year. The inspector noted that it identified areas of good practice, areas for improvement and actions were identified at the end of the report with persons responsible for completing the actions. However, the inspector noted that some of the actions were disjoint in all of the reports and were not shown consistently across all documents. In addition, there were no clear time bound plans in place to complete the actions and as said previously some were outstanding from a 2021 inspection report.

There were robust management arrangements in place which ensured that there was a good level of compliance with regulations, and that a good quality and safe service was provided for the resident who lived in this centre.

Audits were being carried out by the person in charge and staff to review the quality and safety of the service. A monthly audit plan for 2023 had been developed and specific audits were identified to be carried out each month. These included audits of fire safety, finances, health and safety, medication, infection control compliance, and restrictive practice The required audits had been completed to date. The provider was aware of the requirement to completed unannounced audits on behalf of the provider twice each year, and these processes were in place and completed. Two unannounced audits had taken place in 2022, and the provider had identified

areas of good practice and areas for improvement, such as activity sampling. The annual review of the service was completed and due for an update this year. The inspector noted that it identified areas of good practice, areas for improvement and actions were identified at the end of the report with persons responsible for completing the actions.

The centre was well managed, with good systems and levels of oversight to ensure that the residents' needs and well-being were being prioritised. There was a strong management presence in the centre with a clearly defined management structure led by the person in charge. There was a schedule of audits in place that ensured that the centre's information and practices were being effectively monitored. The inspector reviewed audits that had taken place and found them to be thorough and that the actions and their completion dates were documented. The person in charge was delegating audit tasks to the staff team and was supporting them to complete them, and in doing so was creating a learning environment. The person in charge knew the residents and their support needs. The person in charge worked closely with staff and the wider management team. Regular management meetings took place, which were attended by the person in charge and the management team and the person in charge kept the regional services manager aware of service needs or issues. The person in charge held monthly team meetings with the staff in the centre at which a range of information was shared and discussed such as care planning, health and safety, risk management, policies and procedures, and notifications. In addition, The inspector noted that staff adhered to a cleaning schedule in place and ensured that all jobs were completed and recorded at the time of inspection. The inspector noted that the person in charge also reviewed and monitored these records and had an audit schedule in place to guide their practice.

There were robust management arrangements in place which ensured that there was a good level of compliance with regulations, and that a good quality and safe service was provided for the resident who lived in this centre. However, as said earlier improvements were required as actions were outstanding from 2021 and on the day of this inspection there was no timebound plan in place to address all areas. In addition, the person in charge was not provided with suitable time for their administration duties, which was eight hours a week, as they were covering ongoing staff shortages to ensure consistent staffing was provided for residents and as said they were exceeding their contracted hours each fortnight as seen on records reviewed over a six week period.however the person in charge was covering front-line hours to replace staffing where two vacant positions were in place. On review of the roster the person in charge was allocated eight hours a week supernumerary to complete all administration duties which did not take into consideration the oversight and responsibilities for this role in this centre. The inspector found that over a period of six weeks the person in charge had worked an average of 98 hours a fortnight as recorded on rosters and time-sheets available on the day of the inspection. While the person in charge was ensuring that they were reporting, and monitoring this service effectively they had not received the appropriate allocation of supernumerary time in the centre.

On review of the rosters the inspector noted that there was insufficient staff rostered for duty to support the resident's assessed needs. While there was

adequate staffing arrangements in place which enabled the residents to take part in the activities that they enjoyed and preferred.However, adequate staffing was only achieved through the use of agency workers and the person in charge working front line to cover staffing gaps which had a potential impact on their managerial and administration duties. At present there were two staff vacancies which comprised of 60 hours a week that required filling. There were also measures to ensure that staff were competent to carry out their roles. The staff team supporting the resident had access to appropriate training as part of their continuous professional development. The inspector reviewed the staff team's supervision schedule and saw that staff members were receiving this regularly. A sample of staff members' supervision records were examined and were found to be promoting learning.

There was an effective complaints procedure that was accessible to the resident. The inspector reviewed the centre's complaints log and noted that there were systems to respond to complaints in a prompt manner. Staff spoken with were clear that if the resident was unhappy or had an issue they would clearly indicate their annoyance and if it was not addressed this would result in a behavioural issue as outlined in the behaviour support plan. There were no active complaints at the time of this inspection.

Overall, the inspector found that the oversight of day-to-day care practices was of a good standard and provided the resident with a good quality of care, however improvements were required in staffing, statement of purpose, and governance and management of this centre.

Regulation 15: Staffing

There was a planned and actual roster available on the day of the inspection which showed staff's working hours in line with their contracts, their roles, however the hours worked by the person in charge were not shown on all rosters in the centre. As a result the inspector found that each house showed the hours they worked in this house specifically and failed to show their presence throughout the centre.

Furthermore, on review of the roster, the inspector found that there were two unfilled vacancies which resulted in 60 hours a week which required filling. This time was filled by relief staff and the person in charge who was increasing their hours working front-line due to the gaps evident on the rosters. Tthe person in charge was covering front-line hours to replace staffing where two vacant positions were in place. On review of the roster the person in charge was allocated eight hours a week supernumerary to complete all administration duties which did not take into consideration the oversight and responsibilities for this role in this centre. The inspector found that over a period of six weeks the person in charge had worked an average of 98 hours a fortnight as recorded on rosters and time-sheets available on the day of the inspection. While the person in charge was ensuring that they were reporting, and monitoring this service effectively they had not received the appropriate allocation of supernumerary time in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

On review of training records and staff support, the inspector found that the person in charge had ensured that all mandatory training was completed and a schedule for refreshers was also planned. Furthermore, staff were receiving their support meetings in line with the organisational policy and this was facilitated by the person in charge.

Judgment: Compliant

Regulation 23: Governance and management

While the provider had a management team in place in the centre the inspector found that the systems in place were disjointed. This included;

- Audits were being completed, however the inspector found that the information was very disjointed and were not reflected in all documents showing the areas for improvement in this service.
- The person in charge was covering frontline shifts due to staffing shortages.
- In addition, the inspector found that actions from an inspection in 2021 had not been completed and were still ongoing on the day of this inspection. This included extensive maintenance work required in two houses which now involved further deterioration in all three houses in the centre.
- The inspector found that audits in this centre had not reviewed or identified the gaps found during the inspection.
- The inspector noted that the issues evident were not all reflected on all documents to ensure awareness and that no actions were overlooked.
- Therefore, there was no overarching plan to address all areas for improvement in a timebound manner.
- Maintenance was required internally as well as externally, in one house the paintwork on the front door was worn and chipped as well as garden furniture around the centre. The gardens were also unkept and overgrown in areas throughout the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had not ensured that the statement of purpose was update every year as required, and the copy available was dated for 2021 and did not reflect the current management stricture in place as required in the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had ensured that all appropriate incidents were reported to the chief Inspector as required within specified time lines.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. A complaints log was maintained, and complaints and complements were recorded and acted on appropriately. All staff spoken with were clear that residents would indicate clearly if they were unhappy with an activity, staff or during an outing and they would make their preference clear or it could result in an adverse event.

Judgment: Compliant

Quality and safety

There was suitable care and support provided in the centre to allow residents to enjoy preferred activities and lifestyle and to receive a good level of care and support as per their assessed needs, however improvements were required in the risk management and premises in the centre.

The provider had ensured that each resident had a person centred individualised programme in place which provided access to recreation, meaningful day-to-day activities. Residents enjoyed activities such as, table top activities, drawing and enjoying walks in scenic areas as well as day service and individualised activities for some residents. Residents also enjoyed short walks in local areas of interest, eating out and beverages in local places of interest. Some of the residents also had a good family support system and was supported with goals or appointments by family members, who engage with staff regularly to ensure the resident was receiving relevant and appropriate care.

The provider and person in charge were also ensuring consistency for residents as this was paramount to maintaining residents wellness and ensuring a person centred programme was in place and they had regular access to their local community. In addition, the inspector reviewed the induction documentation to guide all staff in their practice and the inspector found it was very detailed and clearly outlined how the residents liked to be supported during the day and programmes in place.

There were three houses in this centre which were laid out and suitably decorated in line with the residents assessed needs. From speaking with the person in charge the management team were discussing and planning for the aging needs of residents however significant improvements were required in all three houses. Some of the works required were outstanding from the last report findings in 2021 and additional works were evident due to some works completed, however at the time of the inspection, there was no clear timebound plan in place which incorporated all jobs required in the centre. This will be further outlined under the premises compliance information.

The systems for the protection the residents from abuse were satisfactory in all areas in the centre. The inspector found that appropriate policies and procedures were in place. These included safeguarding training for all staff, a safeguarding policy, development of personal and intimate care plans to guide staff and the support of a designated safeguarding officer in the region. The provider had systems in place to ensure that this resident was were safe fro all risks. These included a risk identification and control, a health and safety statement and a risk management policy. Both environmental and individualised risks had been identified and were reviewed frequently by the person in charge and management team.

Although the provider had risk management systems in place, aspects of this system required improvement to ensure it better supported this centre in the identification, response and monitoring of risk. For instance, the provider had established monitoring systems to identify risk in this centre, some of these proved ineffective, particularly in relation to identifying the risk posed to the premises, and staffing. Furthermore, with the aforementioned limitations on the capacity of the person in charge, this also posed a risk to this centre's oversight and monitoring arrangements, which at the time of this inspection, had not been responded to by the provider. Even though there was a risk register in place for this centre, it required further review to ensure it better supported the provider in the on-going review of specific risk in this centre, particularly in areas such staffing, and management of premises.

Residents' rights were promoted by the measures and actions which were implemented by the provider, person in charge and the staff team. The provider ensured that the centre was well resourced and that residents could freely access their local community, nearby towns and shopping areas. The person in charge displayed information on rights and reviews which were facilitated in the centre aimed to promote residents' welfare and wellbeing. In addition, the inspector observed staff interacting with the resident in a kind and respectful manner and daily notes which were reviewed indicated that the best interests of residents was to

the forefront of care.

Although this inspection did identify where significant improvements were required to aspects of risk, premises and governance and management and staffing, it is important to note, that this did not directly impact, or take away from, the quality of life and quality of care that that these residents received in this centre.

Regulation 13: General welfare and development

Residents were supported to take part in a range of social and developmental activities both at the centre, at day services and in the community. Suitable supports and resources were provided to residents to achieve this in accordance with their individual choices and interests, as well as their assessed needs.

Judgment: Compliant

Regulation 17: Premises

The inspector found that areas for improvement identified in a 2021 report were not completed by the provider within the timelines they had specified in their compliance plan response in Aug 2021. While the houses were clean and tidy, and met the needs of the residents at present, there was significant work required in all three houses in the centre but there was no clear timebound action plan in place to address the actions required, which had also increased. Actions included:

- New bathroom fixtures including tiles and sanitary ware since Aug 2021
- painting throughout the centre internally and now required externally
- New flooring required in a sitting room and hallway as identified in 2021 report outstanding on this inspection.
- Crack over en suite in staff room not addressed
- repairs to foot path not completed beside a front door.
- Garden areas were unkempt, overgrown and dishevelled in appearance.
- Modifications required in two bathrooms due to the age and wear of these facilities.
- Curtain and blind poles were rusty and worn in the bathroom in first house
- Damage to the floor in kitchen and utility in first house due to removal of a radiator and heating boiler.
- Saddleboards in two rooms showed noticeble dust, debris and discolouration evident.
- Mould remained an issues in all three houses, although industrial cleaning was completed, the mould returned within two months in all three houses as

discussed with staff team.

Judgment: Not compliant

Regulation 26: Risk management procedures

Overall the provider had ensured that risks were identified, monitored and regularly reviewed, risk assessments were up to date, and there was a risk management policy to guide practice, however improvements were required as the inspector noted that two areas for improvement were not shown on the risk register. This included,

- staffing gaps on the roster
- maintenance work required

Judgment: Substantially compliant

Regulation 28: Fire precautions

Overall, the provider had ensured that good measures were in place to protect residents and staff from the risk of fire. This included, appropriate evacuation plans, fire drills and monitoring of the fire equipment to ensure there was no areas for improvement.

Judgment: Compliant

Regulation 6: Health care

The health needs of residents and respite users were assessed and they had good access to a range of healthcare services, such as general practitioners, healthcare professionals and consultants as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Appropriate systems were in place to respond to behaviours of concern. This included training which guided staff. The service had access to behaviour support

specialists when required.

Judgment: Compliant

Regulation 8: Protection

The provider had appropriate systems in place to ensure that all residents were safeguarded in this centre. On the day of the inspection, there were no active safeguarding plans in place and on review of the training records, all staff were trained in lined with the organisation policy.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were paramount in this service with a great level of appropriate risk taking which further promoted the residents choice and access to activities of interest. This included one resident enjoyed some social drinks every Friday evening and had also organised their birthday party without staff assistance in their place of choice. In addition, some residents were supported to spend time alone in the centre. Another resident had chosen to undergo medical treatment but chose to live at home with family while receiving this treatment. The centre had supported the resident and family throughout this process.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ash Services OSV-0004695

Inspection ID: MON-0035506

Date of inspection: 08/06/2023

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: • Person in Charge frontline hours are now shown on rosters throughout the centre – Completed by 9th June 2023 • Governance and management hours for the person in charge are shown on both rosters – Completed by 9th June 2023 • Staff (all grades) have been Interviewed and are currently going through the recruitment process- to be completed by 30th September 2023 • The Person in Charge has been allocated additional supernumerary hours to complete all administration duties, and ensure better oversight of this Designated Service. – 3rd July 2023	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The person in charge will ensure that all areas requiring improvement will be captured consistently in future audits – by 30th September 2023 and ongoing • The Person in Charge has been allocated additional supernumerary hours to complete all administration duties, and have better oversight of this Designated Service – 3rd July 2023 • While some works had been completed, for example kitchen upgrades in three houses, Dining room flooring replaced and footpath repaired by the Housing Association. The Service Provider has now given a commitment that the remaining maintenance works will be completed in a timely manner – upgrade of bathrooms in two houses, replace flooring, garden maintenance and painting – by 31st December 2023	

• The Auditing system will be reviewed to ensure all areas requiring improvement will be documented in each Audit – by 30th September 2023
• An overarching time-bound plan will be devised to address all areas for improvement- by 30th September 2023
• All outstanding maintenance will be completed in a timely manner- by 31st December 2023

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been updated and now reflects the current management structure and current staffing levels – Completed on the 8th June 2023

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The crack on the footpath has been repaired

The Service Provider has a time bound plan in place for outstanding works will be completed

• The bathrooms in two houses will have a complete upgrade, including tiles and sanitary ware, and fittings – by November 2023
• The flooring in the sitting room and hallway will be replaced –by October 2023
• The crack in the ensuite will be repaired- by October 2023
• The gardens and shrubbery will be attended to, to ensure they enhance the appearance of peoples' homes- by September 2023
• The flooring will be replaced in the kitchen where the radiator and boiler was removed- by October 2023
• Cleaning checklists have been reviewed to ensure thoroughly cleaning. Saddle boards will be replaced – by October 2023
• An external company had carried out a Home Energy assessment on these houses. Recommendations have now been received and will not be acted upon. This includes, full attic insulation which will eliminate the mould – by December 2023

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Staffing deficits have now been included on the risk register
• Outstanding maintenance works have been included on the risk register under premises
This action was completed on 8th June 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	30/09/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/12/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the	Not Compliant	Orange	30/09/2023

	effective delivery of care and support in accordance with the statement of purpose.			
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	03/07/2023
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	08/06/2023
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	08/06/2023