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:	A2
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	27 March 2024
Centre ID:	OSV-0005387
Fieldwork ID:	MON-0043178

About the designated centre

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

The designated centre is comprised of three individual units and is located on a shared campus setting in West County Dublin. It provides 24-hour residential support services to persons with intellectual disabilities and at the time of inspection was supporting 13 individuals. The three units of the centre had similar layouts and included an entrance hallway, a living and dining room, a small kitchen area, accessible bathrooms and individual bedrooms for residents. The staff team was comprised of a person in charge, a social care leader, staff nurses, carers, an activity coordinator and household staff members.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 27 March 2024	09:00hrs to 17:30hrs	Karen Leen	Lead
Wednesday 27 March 2024	09:00hrs to 17:30hrs	Marie Byrne	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed following receipt of both solicited and information from this designated centre. This solicited information related to the notification of allegations of abuse, and two pieces of unsolicited information were received by the Chief Inspector of Social Services in the form of concerns relating to safeguarding, residents' rights, transitions, governance and management, and the quality of care and support for residents. A provider assurance report was issued to the provider following receipt of the first piece of unsolicited information, and the second which was recently received was used as lines of enquiry for this inspection. In addition, following a trend of allegations of abuse in the centre in late 2023, further information and additional assurances were requested from the provider to ensure they were being responsive and implementing the required control measures to reduce the presenting risks.

Overall, the findings of this inspection were that while the provider had policies, procedures, guidance and systems in place, these were not being fully implemented or proving effective at the time of the inspection. The inspectors of social services found that some improvements had been made in relation to staffing numbers and continuity of care and support for residents since the last inspection; however, further improvements were required to ensure that each house in the centre was resourced to meet the number and needs of residents living in the centre during the day and at night. Areas of good practice were found in relation to safeguarding, risk management and staff training and development. Areas where further improvements were required were identified in relation to oversight and monitoring of care and support and documentation in the centre, residents' access to meaningful activities, staffing numbers in the centre at times, and residents' access to their finances.

The centre comprised of three bungalows located on a large campus in West Co. Dublin. The inspectors visited all three houses that make up this designated centre during the course of the inspection. The designated centre is registered for 15 residents, at the time of the inspection there was ten residents living in the centre. The inspectors had the opportunity to meet all residents during the course of the inspection. Most residents communicated verbally, while some residents used body language and gestures to communicate their wishes and preferences. The inspectors also used observations, discussions with staff, and a review of documentation to find out what supports were in place for residents in the centre. Over the course of the inspection, inspectors observed residents being supported to engage in activities of their choosing within the designated centre. A number of residents were supported by staff from the centre and day activity staff to attend an Easter party in the day service building. One resident who did not wish to attend the party was assisted with an alternative choice of a shopping trip. While the inspectors found evidence of activities for residents to participate in within the designated centre and the providers day service, there was limited evidence to demonstrate the activities on

offer for each resident outside of the designated centre.

Residents had televisions in their bedrooms, and tablet devices. They had access to arts and crafts supplies in their homes and some residents were interested in crafting and knitting. One resident was knitting a tea cosy to give to their family member as a present. Residents spoke with inspectors about things they liked to do, and things they had to look forward to such as Easter celebrations and visits with their families. They spoke about liking to go out for lunch and on shopping trips. One residents told inspectors they would talk staff if they had any worries or complaints.

A number of works had been completed in the premises since the previous inspections which had resulted in residents' homes appearing more homely and comfortable. There were more photos and art works on display in communal areas and residents' bedrooms were decorated in line with their wishes and preferences. Each of the three houses were found to be very clean during this unannounced inspection.

The provider had recently implemented a business case in the designated centre which saw an increase in the centres whole time equivalence staffing. The additional staffing was being utilised in one house in the designated centre that had documented a change in the assessed needs of residents with residents requiring the support of two staff during personal care, meal times, falls prevention and fire evacuation. An inspector had the opportunity to meet with residents and staff within the house. Staff spoke of the immediate positive impact that the increased staffing was having on the quality and safety of the service provided.

In one house a resident spoke to the inspector about activities they took part of in their home. The resident had a great talent for arts and crafts and regularly made jewellery and pattern blanket work. The resident told the inspector that they regularly go to the day service situated on campus and that they enjoy the staff there and meeting residents from other centres. The resident particularly enjoys doing pottery and spending time with residents that they once lived with. The resident told the inspector they were very happy in their home and that staff knew them well and knew the things that mattered to them. The resident discussed that they would like greater access to community activities.

Later in the day one resident spoke to the inspector on return from the Easter party, they had recently celebrated their birthday and were showing the inspector and staff their new watch. The staff informed the inspector the the resident liked to know the time and where staff were. The resident liked to know what was going to happen next throughout the day. The staff told the inspector that the increase in staffing during the day was having a positive impact on residents overall well being and healthcare.

Inspectors observed residents completing art work, knitting and enjoying listening to music during the course of the inspection. Residents art work and knitting designs such as blankets, stuffed teddy bears and cushions were on display throughout the designated centre. Residents spoke to inspectors about the enjoyment they get from

making designs for the house and for family and friends.

Warm and kind interactions were observed between residents and staff throughout the inspection. Staff were observed to be very familiar with residents' communication preferences and to take the time to listen to and reassure residents when they needed them.

Residents' meetings were held at least monthly. There were limited agenda items for some of these meetings and three different templates in use and this is discussed further later in the report. House meetings were also held weekly to discuss menu and activity planning. There was easy-to-read information available for residents in areas such as, safeguarding, complaints and infection prevention and control.

The next two sections of the report present the findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

This inspection was a risk-based inspection carried out in response to both solicited and unsolicited notifications from November 2023 to the day of the inspection. The provider had systems for oversight and monitoring in the centre but inspectors found that some of these were not being utilised at the time of this inspection.

The provider had recently increased the day time whole-time equivalent staffing levels in the designated centre in order to meet the changing needs of residents in one house within the centre. However, inspectors were not assured that resources were appropriately available to residents at night time, where residents required the support of two staff for a number of assessed needs including personal care and fire evacuation. Inspectors found that the each house in the centre had access to one staff during night time hours with assistance provided from one staff on call from another centre on campus. The additional support staff which attended the designated centre when required was also responsible for three houses in another designated centre totalling a support of six houses at night. Inspectors found on review of documentation and discussion with staff that four residents in the designated centre required 2:1 supports at night time. On the day of the inspection there were three staffing vacancies. A review of rosters demonstrated a reliance on agency and relief staff in order to cover vacancies, annual leave and sick leave.

A quality enhancement plan was in place for the designated centre, however the inspectors found that the plan had not been reviewed since January of 2023 despite provider recommendations of monthly review between the person in charge and senior management. Evidence could not be provided on the day of the inspection to demonstrate that regular staff meetings were occurring. Inspectors reviewed

minutes from three staff meetings on file from a 12 month period.

There were arrangements in place to monitor staff training needs and to ensure that adequate training levels were maintained. Staff received training in key areas such as safeguarding adults, fire safety and infection control. Refresher training was available as required and staff had received training in additional areas specific to residents' assessed needs. The person in charge provided support and formal supervision to staff working in the centre.

The inspectors spoke with staff members on duty throughout the course of the inspection. The staff members were knowledgeable on the needs of each resident, and supported their communication styles in a respectful manner.

The information governance arrangements were not ensuring secure record-keeping and file management systems were in place. Throughout the course of the inspection the inspectors sought various records and documents pertaining to the delivery of care to residents and found that some pertinent records were not accessible or were present in multiple forms. The annual review completed for the centre stated that contracts of care were in date and reflected the updated schedule of fees. However, inspectors found there were no contracts of care available in the seven residents' files reviewed by inspectors during the inspection.

The inspectors found a number of occasions where a notification of an incident had not been reported appropriately in line with the regulations to the Chief inspector. For example, the provider had not submitted the required notification for any injuries other than those notified under an NF03.

Regulation 15: Staffing

The inspectors found that some improvements had been made in relation to staffing numbers for the designated centre. However, the centre was operating with three whole time equivalent vacancies at the time of the inspection. These positions were filled by a panel of regular relief and agency staff which somewhat supported continuity of care for residents.

The inspectors found that the planned and actual rosters were not readily available for viewing by staff in the designated centre. Inspectors found that rosters available in the designated centre did not demonstrate when staff were on leave, if a shift had been covered, or the name or title of the staff on duty. Furthermore, staff spoken to on the day of inspection noted that rosters in place did not always identify if a shift had been covered or if this shift had been covered by agency or relief staff.

The provider had implemented a induction checklist for new staff or agency staff in the designated centre, however inspectors found that this induction checklist was not being fully utilised within the designated centre. For example inspectors could only find evidence of two inductions completed from January 2024 to the day of the inspection, with evidence that 13 separate agency staff had been used during this

time frame.

In relation to night time support for residents in the designated centre, each house in the designated centre had one staff staff on duty at night time.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured that all staff had access to appropriate mandatory training to ensure staff met the assessed needs of the residents. In addition, staff were scheduled to complete identified outstanding training. The person in charge had a schedule of supervision in place for the staff team.

Judgment: Compliant

Regulation 21: Records

Some of the records required under Schedule 4 of the regulations were not available for inspectors to review during the inspection such as a record of the designated centre's charges to the resident including any extra amounts payable for additional services not covered by those charges. Inspectors were informed that residents' contracts of care were under review at the time of the inspection but there were no contracts of care available in the seven residents' files reviewed by inspectors during the inspection. In addition, some residents financial passports and weekly income and expenses plans were not fully completed.

Inspectors were furnished with a sample of residents' statements of account but these did not clearly demonstrate that waivers relating to food shopping were consistently applied to residents.

Inspectors found inaccuracies in relation to training records for staff. The record held by the provider stated that all staff members were reaching 100% completion on all areas of training, however when reviewed by inspectors it was identified that two staff were out of date for infection protection control training and three staff were out of date for hand hygiene.

In addition, inaccuracies and inconsistencies were found across a sample of residents' plans reviewed and some parts of their assessments and personal plans were not completed. For example, sections of some residents' health and well being summaries did not correlate to their assessment of need and some sections were unfilled. In one residents' plan the activity sheet did not match the meaningful activity record on a number of occasions.

Judgment: Not compliant

Regulation 23: Governance and management

As previously mentioned staffing numbers and continuity of care and support had improved in the centre since previous inspections; however, based on a review of residents' dependency needs and risk assessments it was not clear that staffing resources were being utilised effectively to meet residents care and support needs on a 24/7 basis. For example, there were five staff rostered in the centre on the day of the inspection across the three houses; however, there were times during the day when there was only one staff available to residents in two of the houses. These included times when residents were being supported with their personal care and during meal times. In addition, there was one staff working in each of the houses at night and they were supported by a staff nurse who was covering the three houses in this designated centre, and three houses in another designated centre. There were a number of resident who have been assessed to require 2:1 staffing with fire evacuation and personal care in this centre.

Inspectors found that the governance and management arrangements in the centre were not effective in ensuring adequate oversight of the quality and safety of residents' care. The provider had systems for oversight and monitoring in the centre but inspectors found that some of these were not being utilised at the time of this inspection. For example, the provider had not carried out their most recent 6 monthly audit in line with regulations. The last recorded six monthly audit for the designated centre was the 27 April 2023. The inspectors were informed that an unannounced six monthly audit had been completed for the designated centre in January of 2024, however, this six monthly audit was not available in the centre and not made available to the inspectors on the day of the inspection. Furthermore a quality enhancement plan (QEP) for the centre which was required to be updated with senior management on a monthly basis had not been reviewed since the 01 January 2023.

On the day of the inspection evidence could not be shown to the inspectors to demonstrate that staff meetings were occurring regularly in the centre. Inspectors reviewed three staff meetings occurring in the centre over a 12 month period, with no evidence that the minutes of these meetings had been reviewed by the entire staff team or that they were being retained in the houses of the designated centre so that actions identified could be implemented within the designated centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place which met the requirements of the regulations and schedule 1 and clearly set out the services provided in the centre and the governance and staffing arrangements. A copy was readily available to the inspectors on the day of inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications of incidents were not reported to the Office of the Chief Inspector in line with the requirements of the regulations.

Judgment: Not compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspectors found that there were enhancements required to ensure that residents were in receipt of quality care that was being delivered in a safe environment. For example, inspectors found that residents required greater support to freely access their personal finances and create greater opportunity to participate in social activities away from the designated centre.

There was a risk management policy and associated procedures in place. There was an accurate risk register in place that reflected the risks identified in the centre. The processes in place ensured that risk was identified promptly, comprehensively assessed and that appropriate control measures were in place.

A structure was in place to identify and support residents with social, recreational and life development goals and opportunities. However, the inspectors were provided limited evidence to indicate how progress towards attaining these objectives was being achieved or discussed with the residents. From the sample of residents meetings reviewed across the three houses topics discussed in these meetings were mostly limited to menu planning and activities. Inspectors did not view any minutes where discussions were held in relation to safeguarding, human rights, social activities, or complaints were discussed. Inspectors found a number of different templates used to capture the residents views however inspectors found limited evidence that these appropriately captured residents views on activities or the running of their home.

Inspector found that some residents did not have full access to or control of their financial affairs. Inspectors found that residents could not access larger sums of

money outside of the providers business hours. Inspectors found that while residents had access to finances that were kept secured within the designated centre, if residents required larger amounts of their personal money a request would have to be sent to the providers finance office between office hours of 9am and 4pm on Monday through to Friday.

The inspectors reviewed the safeguarding arrangements in place and found that residents were protected from the risk of abuse. Staff had received training in safeguarding adults. There were clear lines of reporting and any potential safeguarding risk was escalated and investigated in accordance with the provider's safeguarding policy. Potential safeguarding risks were reported to the relevant statutory agency.

Regulation 12: Personal possessions

Inspectors found that some residents had limited access to their finances. For example they did not have accounts in their name in financial institutions and were limited to a cash withdrawal of 400 euro per transaction from their private property accounts. In addition, they could only collect their money from the finance office between 9am and 4pm. From a review of a sample of residents' financial ledgers they usually had between 50 and 200 euro available to them in their wallets.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Inspectors reviewed a sample of residents activities and identified that residents were given the opportunity to participate in a number of activities based within the designated centre and the providers day activity centre. However, inspectors found that residents access to community and social activities activities was limited with residents highlighting with inspectors their want for further recreational activities outside of the designated centre. Inspectors reviewed a selection of residents files and noted that during the period of January to March 2024 only five activities had been recorded for those residents outside of the designated centre or the campus setting.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Residents, staff and visitors were protected by the risk management policies,

procedures and practices in the centre. There were systems for reporting and following up on incidents and adverse events. The provider was reviewing these to identify trend and to see if additional control measures were required. The risk register was reflective of the presenting risks and incidents occurring in the centre. There were general and individual risk assessments which were developed and reviewed as required. The provider had systems for responding to emergencies and for ensuring that vehicles were roadworthy and regularly serviced

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the safeguarding policies, procedures and practices in the centre. Staff had completed safeguarding and protection training and allegations and suspicions of abuse were reported and followed up on in line with the provider's and national policy. Safeguarding plans were developed and reviewed as required. The most up-to-date safeguarding plans which had been reviewed, updated and closed off were not available in residents' files. This is captured under Regulation 21.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for A2 OSV-0005387

Inspection ID: MON-0043178

Date of inspection: 27/03/2024

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC maintains the live rosters on a central drive, the PIC will ensure that all staff are aware of how to access the rosters on the drive, which are maintained and updated to reflect roster changes in the event of cover required. The PIC will ensure that rosters are reflective of the skill mix and resident need, and staff allocation will be reflective of resident need. Where required the PIC will escalate to the ADON increased levels of need. An induction folder has been created for the centre, the PIC will ensure that this is maintained and ensure that all staff are aware of the induction process, the records of induction will be kept in each house. The centre has 2 relief staff who are covering vacant posts, this ensures consistency for residents, where possible relief staff will be utilised first prior to agency staff. There is ongoing recruitment in the centre to fill vacancies. Each house is supported by 1 staff member at night, a staff nurse is available for support if required and the site is managed by a CNM3 out of hours manager.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A copy of the residents contract of care will be filed in the residents care plan to ensure it is accessible to residents and staff at all times. The contract of care includes a summary of services included in the charges and what is not covered in the charges. The PIC will ensure that the residents financial care plan is updated for each resident to include the resident's weekly income, expenses and wavers. The training tracker will be reviewed by the PIC on an ongoing basis to ensure that the percentages of staff who have completed training match the tracker records. The PIC along with the CNM1 will ensure that a review is completed on all care planning documentation to address gaps and ensure consistency and accuracy. Resident meaningful activities and interest checklist will be reviewed by the PIC along with the support of the Key Workers and ensure records are consistent and meaningful.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

The PIC will review staffing resources to ensure available resources are being used effectively to meet the residents care and support needs. There is a schedule in place for the completion of 6 month and annual reviews and this is being supported by the Quality department, PICs are now involved in the completion of the annual review for the centre and in ensuring that the resident is represented in the review. The QEP has been audited by the Quality department and will be maintained and updated by the PIC, this will be reviewed by the ADON on a quarterly basis or sooner if required. Information such as staff meetings will be made available by the PIC and stored in a central location along with being saved on a digital PIC folder which can be accessed by the ADON. The PIC is updating the PIC digital folder with documentation along with ensuring it is available to staff members. The PIC will ensure that all staff are made aware of the meetings and the minutes are read and signed by staff.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC will ensure that notifications are submitted in a timely manner in accordance with the regulation. The PIC will also review incidents to ensure the quarterly notifications are made to HIQA and are consistent with the incident trend analysis and reporting.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: The PIC is exploring options with residents in opening personal accounts in a financial institution which will move away from patient property accounts. Financial supports are being recorded with receipts maintained the PIC will continue to audit finances along with the support of the Finance department.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development: The PIC along with the CNM1 and key workers will support residents in the planning of meaningful activities. This will include resident and key worker meetings and house meetings in planning activities that are meaningful, and person centred. The residents will be supported to take part in activities both on and off campus. The PIC will provide guidance and support to staff with documenting meaningful activities and supporting residents with setting goals and achieving these goals. The PIC will maintain a weekly activity planner which will be reviewed by the ADON. The PIC will ensure that residents interests' checklist are updated to reflect their assessed needs and their wishes and the supports that they require together with the support of the MDT.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/10/2024
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	30/08/2024
Regulation 13(2)(c)	The registered provider shall provide the	Substantially Compliant	Yellow	30/08/2024

	following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.			
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.	Substantially Compliant	Yellow	30/08/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/08/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	13/05/2024
Regulation 21(1)(b)	The registered provider shall ensure that	Substantially Compliant	Yellow	31/05/2024

	records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.			
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/07/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/10/2024
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.	Substantially Compliant	Yellow	31/07/2024
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph	Substantially Compliant	Yellow	30/08/2024

	(d) shall provide for consultation with residents and their representatives.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	13/05/2024
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	01/05/2024
Regulation 31(3)(d)	The person in charge shall ensure that a written report is	Not Compliant	Orange	01/05/2024

	provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).			