



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

## Issued by the Chief Inspector

Name of designated centre:	The Weir
Name of provider:	S O S Kilkenny Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	23 June 2022
Centre ID:	OSV-0005625
Fieldwork ID:	MON-0037222

## About the designated centre

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

The Weir is a designated centre operated by SOS Kilkenny CLG. The centre provides a community residential service for up to 14 adults with a disability. The centre comprises of four separate locations within close proximity of another in an urban area in County Kilkenny. Each property is spacious and tastefully decorated and has private well maintained gardens for residents to avail of as they please. All residents have their own private bedrooms which are decorated to their individual style and preference. The staff team consists of social care workers and care assistants. Health care support were provided by a team of staff nurses. The staff team are supported by a person in charge.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	10
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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 23 June 2022	10:00hrs to 17:55hrs	Conan O'Hara	Lead
Thursday 23 June 2022	10:00hrs to 17:55hrs	Tanya Brady	Support

## What residents told us and what inspectors observed

This was an unannounced and targeted risk based inspection completed following receipt of solicited and unsolicited information of concern submitted to the Chief Inspector of Social Services. The submitted information outlined a number of serious safeguarding incidents which related to residents' safeguarding, management of resident finances and fire safety.

This inspection took place during the COVID-19 pandemic. As such, the inspectors followed public health guidance and HIQA enhanced COVID-19 inspection methodology at all times. The inspectors ensured physical distancing measures and the use of personal protective equipment (PPE) were implemented during interactions with residents, staff team and management over the course of this inspection.

This designated centre is based across four locations which include a large detached two storey house, two small semi-detached houses and a series of interconnected apartments. At the time of the inspection, the designated centre provided a service to ten residents although is registered for a maximum of 14 individuals. The inspectors visited two of the units which make up the designated centre and had the opportunity to meet six residents during the inspection, albeit some of them briefly as residents engaged with their daily routines.

On arrival at the first house, the inspectors were greeted by four residents. Three of the residents were preparing to leave to attend day services and appeared happy as they spoke with inspectors about their plans for the day. One resident remained in the centre and showed the inspectors recent items they had purchased. The resident was observed engaged in arts and crafts later and watched TV. The inspectors carried out a walk through of the premises which was three apartments which interconnected and were presented as one open plan apartment. The apartments consisted of six individual bedrooms, an office, a kitchen, two kitchen/sitting rooms and a number of shared bathrooms. Overall, the premises was decorated in a homely manner and was well maintained with each resident having their own bedroom which they had personalised.

In the afternoon the inspectors visited a second premises. One resident was observed returning from being supported to access the community. The resident spoke with inspectors about the soccer team they follow and noted that they were happy in the service. The inspectors carried out a walk through of the premises which was a detached two storey house. The house consisted of five individual bedrooms, staff office, two sitting rooms, open plan kitchen-dining area and upstairs a shared bathroom. Similarly, the premises was decorated in a homely manner and was well maintained.

Overall the residents who met with the inspectors appeared content and comfortable in their home and the staff team were observed supporting the

residents in an appropriate and caring manner. However, following inspectors review of the identified areas of concern, a number of improvements were identified as required. These included governance and management, fire safety arrangements and the oversight of residents finances. On the day of the inspection, an urgent action plan was issued in relation to fire safety arrangements for the evacuation of all persons from one unit of the designated centre.

The next two sections of the report outline the registered providers non-compliance with a number of the specific regulations reviewed on this inspection and the impact of governance and management arrangements on the quality and safety of care.

## Capacity and capability

This inspection found that there were local management systems in place to ensure the designated centre provided a person centre service. On the day of the inspection, the inspectors observed sufficient staffing levels in place. However, further improvement was required in the governance and management systems in place to ensure a safe and quality service.

There was a defined governance and management structure in place with the provider identifying the need for enhanced oversight from persons participating in management which had begun to take effect. The centre was managed by a full-time person in charge, who was suitably qualified and experienced. A new system of shared learning between persons in charge of all centres operated by the provider had also been established. Residents appeared and stated that they were happy and well cared for.

As noted, there were a number of safeguarding concerns which had been submitted by the registered provider through the notifications process including the oversight of residents finances, the compatibility of the resident group, a serious incident involving one resident, fire safety and an incident whereby vulnerable residents were left unsupported by staff for a period of time. Furthermore unsolicited information had also been submitted through the concerns process and these were reviewed by inspectors with the registered provider.

During the inspection, the provider's senior management met with inspectors and provided assurance that they had instigated investigations where indicated and had fully assessed services that had been in place with actions identified and prioritised. For example, additional oversight systems were developed in relation to staffing, spot checks of staffing levels and additional staffing had been put in place to support residents and manage safeguarding concerns. The provider also had identified that a number of their premises required review in order to meet changing needs of residents and a premises review had commenced.

While, the inspectors found that these incidents had been suitably identified, reviewed and interim safeguarding plans were in place, improvements were required

to ensure the provision of a safe and quality service to all residents in this centre. In addition, while there was evidence of regular quality assurance audits taking place to ensure the service provided was effectively monitored, improvements were required in the oversight systems in place for the management of residents' finances. This is outlined in detail under Regulation 12 below with the provider having commenced a service wide audit and revision of their finance policy and oversight systems.

With respect to the unsolicited information that had been submitted to the chief inspector, the provider was aware of the concerns as identified. Inspectors reviewed the providers management of complaints and found that the registered provider had followed their policy and had made a number of changes to levels of support and to the physical premises in one house. They had in place a complaints process and procedure that was prominently displayed, the complainants satisfaction with the outcome of complaints made were recorded. The inspectors were satisfied that the provider had responded appropriately to complaints.

## Regulation 15: Staffing

The inspectors found on the day of inspection that the provider had ensured there were sufficient staff on duty to meet the residents assessed needs. The person in charge maintained planned and actual rosters which were reviewed by inspectors. The registered provider ensured that the qualification and skill mix of staff was appropriate to the assessed needs of the residents. From a review of the roster there was, for the most part, a consistent staff team supporting the residents. For example, in one house there had been a number of changes to the staff team which had now settled but these changes had not impacted residents at the time.

In another house, it was acknowledged by the provider that the supports in the twilight hours and on weekends did result in residents not being able to spontaneously or independently access their community. However, reviews of this had indicated that the residents expressed a preference to socialise together and that following a day of activity their preference was not to go out and this was reflected in the staffing levels. The person in charge had demonstrated that additional staffing could be deployed if requested. Where agency staff were utilised enhanced oversight was now in place and the providers on-call systems were made explicit.

As noted, there was a serious incident where vulnerable persons, in one unit, were left unsupported for a period of time. While the provider demonstrated that they had taken appropriate action to respond to the serious incident including reviewing staffing arrangements and introducing spot checks, the residents had not been provided with staffing as required at the time of this incident. This is reflected in the judgement found against regulation 23.

At the time of the inspection, the centre had arranged for increased staffing to provide support for one resident during the day. The provider had submitted a

business case to their funder to formalise this staffing arrangement in January 2022 and as the residents' needs had changed further the provider had also discussed these additional needs with the funder. In addition, the provider had increased staffing support for another resident in response to a serious safeguarding concern. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner. One area which required further review was the identified levels of staff support residents required to safely evacuate the premises. This is reflected under Regulation 28.

Judgment: Compliant

### Regulation 23: Governance and management

The registered provider had lines of authority and accountability in place for this designated centre, the staff team reported to the person in charge who in turn reported to the assistant director of services. These lines of authority had not however been effective which had resulted in an incident whereby residents were left without staff support for a period of time. This was as a result of the staff team not utilising the governance and oversight arrangements and on-call systems that the provider had in place. The provider had responded to this incident by increasing spot checks with regard to staff levels and also in enhanced communications with the staff team about systems in place for their use. Changes were implemented regarding the use of agency staffing and the requirements for experienced staffing in locations.

The provider and person in charge had identified that their oversight of all resident's savings had not been in line with their policy and they had failed to protect residents. The inspectors acknowledge that the provider had self-identified this concern and had taken steps to resolve these concerns. This included a current review of their finance policy, systems and procedures in addition to engagement with residents and their families or guardians. This is reflected in further detail in Regulation 12 below.

However, inspectors found that the oversight arrangements in place for the day-to-day management of residents finances also required improvement. For example, the inspectors reviewed a sample of residents finances. It was not evident that the provider implemented a six monthly audit of a sample of resident finances as outlined in their policy. In addition, the inspectors found one instance of expenditure involving a significant sum of money had not been approved by the Chief Executive Officer in line with the provider's policy. At the time of the inspection, the finance policy was being reviewed.

Judgment: Not compliant



## Quality and safety

Overall, the inspectors found the provider was striving to provide a quality person centred service which respected the rights of residents. The inspectors found that the provider had implemented interim measures to manage identified safeguarding concerns. However, improvements were required in two areas including fire safety arrangements and the management of residents' finances.

The area of financial safeguarding and overall safeguarding was reviewed in detail on this inspection. This was due to the high number of notifications, safeguarding concerns and investigations ongoing within this centre. While the provider had taken steps to safeguard residents' finances, the provider had not ensured that the residents' finances had been adequately safeguarded as they remained at risk. For example, the inspectors reviewed the systems in place for the management of resident's personal finances. The inspectors found practices that had historically been in place relating to the safeguarding of residents finances had been inadequate and had put residents' finances at risk. In addition, inspectors reviewed recent records for residents' personal finances and found areas where improvement was still required.

The provider had responded to identified peer-to-peer incompatibility concerns and introduced interim measures to protect residents. The interim measures included a safeguarding plans and additional staffing. The provider was working towards a resolution at the time of the inspection. The provider also had responded to a serious safeguarding concern involving one resident in a prompt manner by providing additional staff and day supports in the short term with ongoing review.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place and fire drills had been carried out at suitable intervals. However, on the day of the inspection, the arrangements in place for the evacuation of all persons in the event of a fire required improvement. Urgent actions were issued by HIQA on the day of inspection in relation to these arrangements.

## Regulation 12: Personal possessions

The inspectors reviewed residents finances across the four units of the designated centre. The provider had prior to this inspection self-identified that they had not followed guidance as set out in their own policy regarding the safeguarding and oversight systems in place for residents finances. The provider had reviewed subsequently reviewed their policy and made a number of revisions and this was waiting for review and sign off by their Board.

The provider on identifying concerns had taken immediate steps to set up new bank accounts for two residents and had held savings for them in advance of the

accounts being operational. The provider had transferred the residents savings to their new account. However, improvement was required to ensure that a full review of residents savings was completed by the provider to ensure all savings had been transferred. In addition, the provider was formally corresponding with all resident's families or guardians to inform them of the changes and outlining the oversight systems that were in place and the additional safeguards. Where residents were supported in the management of their finances by others, the provider was working to ensure they had transparency of systems in place to ensure residents had full access to their own funds.

While the provider was responding to identified concerns, the inspectors found additional areas where improvement was required. For example, each resident had an individual assessment in place around their ability to manage their finances. There was a clear and detailed system in place for the management of day-to-day spending which included daily checks and storage of receipts. The inspectors reviewed actual amounts present in resident wallets and found they all tallied with the daily reconciliation records. However, one assessment reviewed was carried out in 2019 and required review. In addition, at the start of the inspection, inspectors found a cheque that was written to one resident loose in their file that had not been cashed and was dated from 2020. The person in charge had this re-issued on the day of inspection and assurances were given regarding the security of residents funds.

This inspection also found that practices were not in line with provider's policy. For example, monthly financial audit of residents' finances was not always completed monthly for some residents. It was not evident a six monthly 'spot check' audit had been carried out by the provider in line with the provider's policy. Residents' bank card were stored with PIN numbers in residents files and this information was not safeguarded. In addition, one large withdrawal had not been approved by the Chief Executive Officer in line with the provider's policy.

The provider had determined that some residents could manage their finances and property themselves. There were no records of decision making or of monitoring to ensure appropriate arrangements were in place to support residents. Financial risk assessments in place for these residents had determined the risk of financial abuse as low, however as no protections or oversight arrangements were in place it was not possible to assess what may be occurring.

Judgment: Not compliant

## Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. There was evidence of regular fire

evacuation drills taking place.

However, the inspectors identified concerns which were also documented and reported as assessed by the provider, regarding the fire safety arrangements in place in one unit due to a change in the mobility needs of one resident. On review of fire drills carried out in this unit, it was not demonstrable how effective the night time evacuation arrangements (or evacuation with minimal staffing levels) were, as the last night time drill was undertaken in July 2021. In addition, at the time of the inspection in order to best support the resident, the resident was always informed of upcoming fire drills in advance so they were prepared to move. In April 2022, the provider's fire safety officer noted immediate concerns regarding the fire safety arrangements in place. Overall, it had not been demonstrated by the provider that the right arrangements were in place to ensure that all persons would evacuate the unit in a safe and timely manner despite them having identified the concern.

As an outcome of the inspectors findings, the provider was required to submit an urgent compliance plan under this regulation to address this urgent risk. The provider's response did provide assurance that the risk was adequately addressed at present and outlined plans for further review.

Judgment: Not compliant

## Regulation 8: Protection

Notwithstanding, the concerns in relation to management of residents' finances and fire safety which are discussed under Regulation 12 and 28, respectively, the provider had systems in place to safeguard residents. As noted, at the time of the inspection, there were a number of identified serious safeguarding concerns in the designated centre including peer-to-peer incompatibility concerns and one serious safeguarding concern involving one resident. These incidents had been suitably identified, reviewed and responded to by the provider. Interim safeguarding measures were in place including additional staffing and safeguarding plans. The provider also informed inspectors that a premises review had commenced in order to meet the assessed needs of residents.

Judgment: Compliant

## Regulation 9: Residents' rights

The inspectors reviewed a sample of resident meetings which demonstrated that residents were consulted with in the running of the designated centre and decisions

which impact their lives.

It was evident that residents had been supported to engage with independent advocates to ensure they received support that was specific to their preferences and reflected their best interests. While the registered provider was working to ensure that residents were provided with homes that met their assessed needs this was at all times done in full consultation with residents. In addition, where residents had lived together for a long period of time the needs of the group were also fully considered.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
<b>Quality and safety</b>	
Regulation 12: Personal possessions	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for The Weir OSV-0005625

Inspection ID: MON-0037222

Date of inspection: 23/06/2022

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

# Section 1

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

## Compliance plan provider’s response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> <li>• A full review of the Residents personal possessions and finances policy has now been concluded and the final draft has been signed off by the board of management on 26.07.2022.</li> <li>• The Residential Manager/ Team Leader will audit Resident finances on a monthly basis and will maintain records of these</li> <li>• The Residential Manager/Team Leader will audit Residents savings accounts on an annual basis and keep records of these</li> <li>• A six month financial audit will be carried out by the Residential Operation Managers. This will commence in July 2022.</li> <li>• A six-monthly audit by SOS Kilkenny clg Central Finance Personnel will be conducted in relation to the Residents finances. This process will entail a review of a sample selection of accounts across the designated centres. It will also consider the ongoing relevance and suitability of this policy. A report will be issued outlining findings and/or recommendations as appropriate. This will commence in September 2022.</li> </ul>	
Regulation 12: Personal possessions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 12: Personal possessions:</p> <ul style="list-style-type: none"> <li>• The new Resident’s Personal Possessions and Finance policy was signed off by the board on 26.07.22 and will be implemented from 01.08.2022.</li> <li>• The Residential Operations Manager will commenced a six monthly review of resident’s finances in July 2022. This will identify any assessments that are due for review and ensure that’s the managers are completing their financial audits monthly in line with policy.</li> <li>• All residents’ bank cards, pin numbers and other personal items have been removed from files and will be stored in a new security pouch which will be locked.</li> <li>• All withdrawal forms on file have been checked and signed as per policy. As of from</li> </ul>	

01.08.22, the new Resident's Personal Possessions and Finance policy will be implemented and all forms will be signed in line with the new policy

- A Finance audit by SOS Kilkenny clg Central Finance Personnel will be conducted in relation to the Residents finances. This process will entail a review of a sample selection of accounts across the designated centres. A report will be issued outlining findings and/or recommendations as appropriate. This will commence in September 2022
- When a resident wishes to manage their own finances, the Residential Manager/Team Leader will carry out a Money Management Competency Assessment with the resident which will be reviewed on an annual basis.
- A signed comprehensive agreement between SOS Kilkenny clg and the Resident will be put in place stating that the Resident wishes to manage their own finances and clearly indicating what supports, if any, are required from SOS Kilkenny clg to facilitate this.
- The Residential Manager will carry out a risk assessment relating to self-management of finances for the Resident. Protocols, where required will be put in place to help prevent financial and/or material abuse. In the event of suspected financial/material abuse, the agreement will be reviewed and amended as required and the safeguarding process will be put in place.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:  
An unannounced night time simulated drill was carried out at 7.04am on 27.06.2022 with one staff on duty.

All residents and the staff on duty were in bed when the evacuation was announced.

- Res 1 evacuated in 3mins 49 seconds to front door
- Res 2 evacuated in 3 mins 46 seconds to front door
- Res 3 evacuated in 3 mins 20 seconds to front door
- Res 4 evacuated in 5 mins 49 seconds to front door
- It took 6 mins and 28 seconds for all residents to assemble at the assembly point.

An announced day time simulated drill was carried out after lunch on 27.06.2022 while resident 4 was at home alone with staff. The resident was asked if it was ok to time them moving from the couch to the assembly point. The resident said this was ok.

- Resident evacuated in 2 mins and 53 seconds to assembly point.

A second unannounced night time simulated drill was carried out at 7.37am on 28.06.2022 with a second staff taking part in the drill. This was carried out in order for us to ascertain if having two staff on duty would change the evacuation time.

- Res 1 evacuated in 3mins 50 seconds to assembly point
- Res 2 evacuated in 3 mins 45 seconds to assembly point
- Res 3 evacuated in 3 mins 28 seconds to assembly point
- Res 4 evacuated in 6 mins 50 seconds to assembly point
- It took 6 mins and 50 seconds for all residents to assemble at the assembly point.

A third unannounced night time simulated drill was carried out at 7.45am on 19.07.2022 with a wheelchair been used to transfer resident 4. Time to assembly point was 5 mins which was a reduction of 1.50 mins.

A wheelchair will now be kept in the bedroom for resident 4 which will enable staff to move her from the apartment to the stairwell.



Evacuation chair: 14.07.22 two certified trainer's trialled an evacuation chair to assess its suitability for the stairs.

The evacuation chair when trialled with trainer in it, did not have enough space on the two landings to manoeuvre correctly and the trainers deemed that it was not suitable for this stairs.

Following the second drill, Health and safety officer spoke to resident 4 about the need to have electronic door closers on both her bedroom and sitting room door. Resident was shown how these can be operated and they have since been installed.

An agreed strategy has been put in place by behaviour support with input from psychologist to support resident 4 with her overall wellbeing and future plans. This will be a multifaceted plan using a rights based and PCP approach and will be delivered through a trauma informed approach to support the resident to navigate these plans and to feel safe and stable in this process.

An immediate assessment of possible suitable properties was undertaken by the CEO and the Facilities manager in response to the concern raised regarding suitability of premises. Confirmation on Tuesday 28.06.2022 indicated that one property did not have sufficient bedroom capacity and the second was in a country location outside of Kilkenny city. An assessment of the pros and cons of this location highlighted that to move four people without taking account of the will and preference of all residents involved, would not be an acceptable course of action.

In terms of a property that would be appropriate to address the needs of all residents in a more suitable location, this is expected to take 18 month – 2 years to secure such a property .The facilities manager is currently in discussion with local builders and has submitted an expression of interest to secure more suitable homes for the people we support.

## 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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
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.	Not Compliant	Orange	31/10/2022
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	31/10/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management	Not Compliant	Orange	31/07/2022

	systems are in place.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	30/06/2022