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:	Lolek
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	02 August 2022
Centre ID:	OSV-0007740
Fieldwork ID:	MON-0028481

About the designated centre

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

Lolek is a designated centre located in Kilkenny City. The centre provides 24 hour care and support to two residents over the age of 18 with an intellectual disability. The centre is currently a male gender house. The house consists of a kitchen/dining room, two sitting rooms, two bedrooms, one bathroom and WC, a dressing room. Lolek is staffed at all times when a resident is present. The core staffing consists of a combination of Social Care Worker and Health Care Assistants

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Tuesday 2 August 2022	09:00hrs to 17:00hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the two residents that lived in this centre. The residents used different modes to communicate such as, single words, vocalisations, facial expressions and gestures. To gather an impression of what it was like to live in the centre, the inspector observed daily routines with residents, spent time discussing residents' specific needs and preferences with staff and completed documentation review in relation to the care and support provided to residents. Overall, it was found that the care and support being provided was meeting residents' specific needs. The provider and person in charge were striving to ensure that all residents were in receipt of good quality care. Improvements were required across a number of regulations however, to ensure that care was provided in a consistently safe manner and to ensure that residents quality of life was optimised.

The announced inspection took place during the COVID-19 pandemic. As such, the inspector followed public health guidelines which included the use of personal protective equipment (PPE) and regular hand hygiene.

On arrival at the centre it was noted that the bungalow building was situated in a residential setting. The outside of the building was well maintained. The residents in the home had access to two sitting rooms, a kitchen and a main bathroom. There was a utility room located off the kitchen, however, residents could not freely access this area. A restrictive practice in the form of locking this door was in place. This was in place to address a specific identified risk. Each resident had their own bedroom and there was a small room used for storage/dressing room. The premises was clean and overall well kept. There were some pictures on display in the rooms. There was a small outdoor garden to the rear of the property that residents could also access if they so wished.

The inspector met both residents on arrival at the centre. One resident was eating their breakfast in their bedroom while watching a preferred programme on television. At this time the resident did not wish to engage with the inspector. They were seen to bring their bowl back to the kitchen when finished and get a preferred drink for themselves. The second resident was in the small sitting room to the front of the building. They smiled when the inspector was introduced and interacted for a very short period of time. They used a specific phrase that indicated the interaction was over and the inspector left the room.

The residents had plans for the day which included walks in the local area and a visit to the cinema. Staff were seen to support residents with their daily routines and were patient in their interactions. One resident had a specific programme in place that had been devised by the behaviour support specialist. The staff member on duty was seen to follow this programme and explained to the inspector the rationale for this.

Residents were seen to move around their home. Staff supported residents at this time to ensure positive interactions between residents was facilitated at all times. The two residents that lived together often preferred their own space and the importance of having the second communal space was essential to ensure residents' assessed needs were being met. As stated previously, there were some restrictive practices in place. Although there was a rationale for their use, consideration of the impact of restrictions on both individuals that lived in the home had only recently been considered.

Overall the care residents were receiving met each individual's specific needs. The person participating in management and the person in charge spoke in detail about a quality improvement initiative that was taking place in the coming weeks. This included a staff training day to up-skill the current staff team in areas such as Social Role Valorisation and personal planning to ensure residents' days were not only busy but meaningful in line with their individual strengths and needs. Across the day residents appeared content with the care and support they were receiving. Improvements were identified across a number of regulations such, ensuring residents rights were continuously upheld, adherence to effective infection control measures, ensuring a consistent safe environment, and ensuring residents had full access to their finances.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall there were management systems in place to ensure the service provided was in line with residents' needs. It was noted during the inspection process that overall oversight systems had remained effective when management changes had occurred. However, improvements were needed to ensure that effective oversight and timely actions were taken, to ensure consistent safe services were in place. This is discussed in further detail throughout the report.

There was a clear management structure in place. The centre was managed by a full-time, suitably qualified person in charge. The person in charge reported to the Community Services Manager, who in turn reported to the Director of Services. There was evidence of regular quality assurance audits taking place to ensure the service provided was monitored. These audits included the annual review for 2021 and the provider unannounced six-monthly visits as required by the regulations.

As stated previously, it was noted that there were improvements in oversight. There had been a number of changes to management in this centre. On review of documentation and discussion with the current management team, there was now an effective process which ensured that a comprehensive handover occurred during this time and consistent provider oversight was also in place. For example, an

additional six monthly provider audit was completed when the new person in charge commenced. This was to ensure previous actions identified and any other areas of improvement noted were communicated effectively with the new person in charge.

Although the provider audits were identifying many areas of service improvement for the two residents that lived in the centre, additional enhancements in terms of provider oversight were required in terms of a number of areas including risk management, infection prevention and control and residents finances. For example, in relation to residents finances although the provider had identified an issue with a resident's finances in January 2021 this issue remained outstanding on the day of inspection and there was limited evidence that the provider had taking effective action in relation to the same.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted the required information to renew the application for registration for this designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

A new person in charge had recently been appointed to this centre. They were in a full-time post. They were found to have the relevant qualifications and experience as set out by the regulations. The person in charge facilitated the inspection day. Although they had only recently commenced in the post, they had a good knowledge of residents' specific needs and preferences. They had systems in place to ensure sufficient oversight was in place. For example the person in charge had a detailed action plan in place. This action plan had been developed from relevant audits and reviews of the service. The person in charge in the process of completing the relevant actions stated.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual staff rota in place and it was reflective of the staff on duty on the day of the inspection. There was appropriate skill mix and numbers of staff to meet the assessed needs of residents. The provider had improved continuity of care by reducing the number of agency staff used within the centre.

There was one whole time equivalent vacancy on the day of inspection. The provider was actively recruiting for this role.

Judgment: Compliant

Regulation 16: Training and staff development

The staff were supported and facilitated to access appropriate training including refresher training that was in line with the residents' needs. A staff training schedule was in place. A training department was in place to ensure staff were notified of any upcoming training or refresher training needed. The inspector viewed evidence of mandatory and centre specific training records. It was found that the majority of staff were up-to-date for all training. Staff that had recently been identified as needing refresher training in some areas had been booked into relevant training accordingly.

Staff were supervised on a regular basis. Formal supervision, known as quality conversations were occurring in line with the providers policy. There was a supervision schedule in place for all staff. The person in charge had strived to have formal supervision with all staff since they commenced in the role. In addition to this, on the job mentoring was occurring for staff to further enhance their skills in identified areas.

Judgment: Compliant

Regulation 22: Insurance

The provider had insurance in place in the evident of an accident of injury occurring within the centre.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider ensured there was a clearly defined governance structure within the centre which ensured that residents received a service which met their assessed needs. The registered provider had appointed a full-time, suitably qualified and experienced person in charge.

Provider level audits and reviews as required by the regulations had been completed and where actions were identified, plans were in place to address these to improve

the overall quality and safety of care. In addition to this, internal audits, such as medication, restrictive practices, infection prevention and control and safeguarding were completed in line with the providers audit schedule. These audits were identifying areas of improvement. At a local governance level a number of improvements were noted in levels of oversight.

However, improved oversight was required in a number of areas, specifically in relation to provider level oversight. Audits at times were not adequately identifying issues that were present as found by the inspector. Improvements were needed in area of oversight in terms of infection control measures, risk management, residents' finances and residents' rights. Each of the issues found in relation to these areas are discussed under the relevant sections of the report.

In addition to identifying these areas of improvement, the timeliness of the response by the provider needed improvement. As stated previously, a concern in relation to a resident's finances had been reviewed by the inspector. The correspondence available on the day in relation to this issue was first dated as January 2021. This issue remained in place and although the provider took some further action in June 2022 additional measures were not considered or taken to rectify this. As the provider had taken limited actions in relation to this concern, a continued negative impact was noted for this resident.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which outlined the service provided and met the requirements of the regulation. However, some details added to this document were not required by regulations. This was discussed with the provider on the day of inspection.

Judgment: Compliant

Quality and safety

The provider and person in charge were endeavouring to ensure residents were in receipt of a good quality and safe service. From what the inspector observed, residents lived in an overall clean and comfortable home. Residents appeared content on the day of inspection. A number of areas of improvement were required to ensure the service provided was consistently safe, effective and striving for quality improvement. Areas of improvement included, risk management, infection control measures, residents finances and residents rights.

The designated centre was a bungalow building located within a residential setting. On the day of inspection there were some pictures and other items in place to personalise the space to the individuals that lived in the home. Each resident had their own sitting room and bedroom. The residents were seen to move freely between most areas of the home. One area of the home, the utility room, was locked. This restrictive practice was in place to ensure a resident's specific need was met and to mitigate certain identified risks. The home was overall clean on the inspection day. A number of measures were in place to ensure infection prevention and control risks were appropriately managed. However, the provider had failed to identify an ongoing risk for one resident. Due to their assessed needs the furniture in their room required review to ensure it best met their specific needs and also was amenable to infection control procedures.

Relevant risks were discussed with the inspector on the day of inspection. The risk register was in the process of being reviewed and many of the risk assessments reviewed by the inspector were in line with the requirements of the organisation and also the relevant risks posed in the designated centre. However, a small number of risks were identified on the day of inspection that had not been adequately assessed or reviewed by the provider. This included the storage of oxygen and the storage of a 'sharps' box .

Within the organisation it had been identified that residents did not have their own bank accounts.This was ongoing area of improvement at the time of the current inspection. In addition to this on review of the residents' finances, it was found that a resident did not have access to all their monies. This again had been identified by the provider as an area of concern and some measures had been taken. The measures to date had not been effective or found to occur in a timely manner and therefore the resident still had limited autonomy over their own financial matters.

In terms of residents rights some good practices were observed and documented. Regular resident meetings were occurring where different elements of the care and support were discussed with residents. However, there were a number of areas that needed improvement. This included residents access to their own clothes, the impact of restrictive practices on all residents within the home, storage of personal documentation and the use of night checks.

Regulation 12: Personal possessions

Previous inspections across the organisation had identified that residents did not have their own bank accounts. This was also the case within this centre. The provider had made efforts to rectify this such as setting up a working group. There were easy read documents in place that were used with residents to explain the current progress to date with setting up individual bank accounts. Individuals within this centre did not have accounts in their own name.

In addition to this, one resident did not have full access to their personal finances. This was a historical arrangement and was still in place on the day of inspection. Due to this arrangement the resident had accumulated some debt as the provider was funding some everyday expenses for this individual. The provider had taken some steps to rectify this such as sending out correspondence to relevant parties. However, additional measures or steps had not been taken by the provider in a timely fashion to try and resolve this issue.

Judgment: Not compliant

Regulation 17: Premises

The premises was a bungalow building. Each resident had their own bedroom with shared access to a main bathroom. There were also two sitting rooms, a communal kitchen and access to a back garden. There was a utility room available to residents. Overall the premises presented as well kept. Residents had some personal items on display such as pictures of family and friends.

As part of this regulation, adequate storage facilities are required as set out in Schedule 6. It was found that for one resident, the storage of their personal items was not in line with best practice and accessibility. This is addressed under Regulation 9, Residents' Rights.

Judgment: Compliant

Regulation 20: Information for residents

The required information as set out by the regulations was present in the guide for residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured the development of a risk management policy in accordance with the requirements of regulation. A risk register was in place. This register was in the process of being reviewed by the person in charge. For the most part the risk assessments were reflective of current risks and appropriate control measures were in place. However, the storage of oxygen within the home required review. A risk assessment was in place to state that appropriate signage was in

place as a control measure and as an additional control measure. On the day of inspection there was no signage in place to indicate where in the home the oxygen was stored. In addition to this, the possible risk in storing a sharps box in a communal area needed review. The sharps box was moved to a more appropriate storage area on the day of inspection.

Judgment: Not compliant

Regulation 27: Protection against infection

Improvements were required to ensure that the practices in place were in line with the National Standards for infection prevention and control in community settings (HIQA, 2018). Due to the type and location of certain furniture within the home the inspector was not assured that effective infection prevention and control measures were been taken. The relevant risks identified in relation to a resident's assessed need had not been appropriately considered and an ongoing infection prevention control risk was present. For example the bed present was a divan bed. Due to the assessed needs of a resident this required regular cleaning. The material present on the bed did not assure the inspector that this was taking place in line with best practice in relation to infection prevention and control measures.

Judgment: Not compliant

Regulation 28: Fire precautions

There were systems in place of fire safety management such as suitable fire safety equipment, staff training, emergency exits and lighting. Suitable fire containment measures were in place. There was evidence of relevant equipment being serviced on a regular basis.

Fire drills were occurring on a regular basis, including drills were the least amount of staff and most residents were present. Personal evacuation plans were reviewed and found to be comprehensive in terms of residents' specific needs. For example, the plans outline additional aids that could be used to encourage the residents to evacuate. These items were all located in a grab bag at the front door for ease of access in case of an emergency.

Judgment: Compliant

Regulation 6: Health care

The overall healthcare needs of residents were for the most part suitably identified. Health care plans outlined supports provided to residents. Residents were facilitated to attend appointments with health and social care professionals as required. However, one resident required an updated health assessment. This appointment had been made with the resident's general practioner. In addition to this, healthcare plans required development to ensure the most up-to-date information was available to staff. For example, one resident had an emerging minor healthcare need. Minimal specific guidance was available to staff. This required review to ensure the most up-to-date information was available at all times.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

In terms of supporting residents there were up-to-date behaviour support plans in place for residents that required them. Staff spoken with on the day of inspection were able to detail different aspects of the support plan and the rationale for the same. There were some restrictive practices in place in the centre. The provider and person in charge had commenced a formalised review process with all restrictions within the centre. This included referring them to a newly formed restrictive practice committee to ensure all restrictive practices were applied in line with evidence based practices. However, consideration was needed in relation to the impact of restrictive practices on all residents within the centre. This has been addressed under Regulation 9, residents rights.

Judgment: Compliant

Regulation 8: Protection

Appropriate measures were in place to keep residents safe at all times. Staff received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff spoken with, were found to be knowledgeable in relation to their responsibilities in ensuring residents were kept safe at all times. Residents had intimate care plans in place which detailed the level of support required.

Judgment: Compliant

Regulation 9: Residents' rights

The provider was striving to ensure residents were consulted and encouraged to participate in how the centre was run. For instance; resident meetings were taking place. Observations on the day of inspection indicated some good practices in relation to allowing residents make choices, for example a staff member was utilising a tablet device to help one resident choose a movie. However, a number of improvements were needed in this area to ensure that best practice was continually employed to ensure residents' rights were always promoted.

The storage of residents' personal information required review as it was stored in a cupboard in a communal area. Two hourly night checks were in place for both residents. The rationale of this level of support was unclear and there was no clear assessed need documented to indicate why this was required. This was a historical practice from when residents lived in a communal setting and required review.

Some restrictive practices were in place. Some of these practices were prescribed for one resident only, but impacted to the other resident within the home. Consideration of how restrictions were potentially impacting residents rights within the home required improvement.

One resident's clothes were found to be stored in clear plastic boxes in a spare room. Although the resident could access this room, they would need support to remove items from in front of the storage area and help with accessing the clothes from the box. The rationale of storing the clothes in this way required review to ensure it was in the best interests of the resident.

Judgment: Not 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lolek OSV-0007740

Inspection ID: MON-0028481

Date of inspection: 02/08/2022

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
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC and CSM have developed a workplan for all identified areas of concern and actions identified to improve. The work- and action plan is being discussed at governance meetings between the PIC and CSM to ensure progression. This workplan is part of the local governance & oversight in Lolek. The PIC has also implemented an action plan folder with the Lolek team. Each staff member has their own action plan outlining delegated duties, assigned actions from audits, training to be completed, etc. These action plans and progression of same are discussed at Quality Conversations between employees and PIC and improve day to day oversight. Actions in relation to Regulation 12, please find detail in next section.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: The provider has recommenced correspondence with the family of a person supported on 21/06/2022 regarding their finances. The provider is currently awaiting a response from family to confirm date for a meeting to discuss the financial situation. Finance Manager, CSM and PIC will attend the meeting. If agreement can't be reached with the family by end of September 2022 the provider will take next steps to safeguard the person's finances.	

The PIC has submitted also referral for an independent advocate for the person supported.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC is supporting the team through OJM to build further capacity in their understanding and completion of risk assessments. The review of Lolek risk register and all risk assessments will be completed by 30/09/2022.

A review with the GP is scheduled also regarding the requirement of oxygen for the person supported.

The risk assessment for storage of oxygen has been reviewed in line with provider practices. Oxygen signages are used as deemed necessary by the fire experts. H & S department have developed a live document with the Fire Services which outlines not only fire evacuation procedures but also identifies stored oxygen within a designated centre. Fire service has access to this live document to ensure up to date information at all times.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The PIC has contacted H & S and finance department to start the review of a person's bedroom furniture to ensure compliance with Regulation 27. The person is supported to purchase an appropriate bed of choice and suitable in relation to identified IPC risks. Until a new bed has been purchased the PIC ensures oversight over regular and adequate cleaning of the current bed via regular visual checks and completion of cleaning schedules.

A review of the person's wardrobe in line with the Behaviour support plan is currently ongoing. Different options of wardrobes and surfaces within same are being explored and trialed to ensure adequate IPC. Regular visual checks are completed by the PIC. The PIC has ensured the cleaning of person's wardrobe is added to the cleaning schedule for

regular disinfection.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A support plan in line with a person's Kardex has now been developed to guide the team in how to monitor and apply supports for a gentleman.

One person's annual medical GP visit has now been scheduled for completion on the 08/09/2022.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The restrictive practice committee review for the people living in Lolek took place on the 03/08/2022. As part of the review actions have been identified for the PIC and team to trial the reduction of some restrictive practices, such as e.g., locked doors, night time checks, etc.

The storage of archive files in Lolek has been reviewed. Archive files are now stored within a press in the utility room.

A night checks review was completed with night staff members and PIC on the 24/08/2022 as part of a topic specific Quality Conversation. It was identified that one gentleman does not require any night time checks. For the other gentlemen a reduction to 4-hourly checks has been agreed in line with his Behaviour support plan. This will be further reviewed in line with the personal plan monthly reviews.

Storage of clothes to be reviewed with BSP. PIC and team to review with the person supported the wardrobe and clothes, support person in skill development of putting clothes back into wardrobe, explore option of chest of drawers and new wardrobe.

Storage of clothes to be reviewed with BSP. PIC and team to review with the person supported the wardrobe and clothes, support person in skill development of putting clothes back into wardrobe, explore option of chest of drawers and new wardrobe.

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.	Not Compliant	Orange	02/09/2022
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	02/09/2022
Regulation 26(2)	The registered provider shall ensure that there	Not Compliant	Orange	30/09/2022

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	05/09/2022
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	08/09/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the	Not Compliant	Orange	30/08/2022

	freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/08/2022