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:	The Court - Kingsriver
Name of provider:	Kingsriver Community Holdings Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	07 December 2021 08 December 2021 and 10 December 2021
Centre ID:	OSV-0007915
Fieldwork ID:	MON-0031980

About the designated centre

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

The Court - Kingsriver is a designated centre operated by Kingsriver Community Holdings CLG. The designated centre provides a community residential service for up to nine adults with a disability. The centre comprises of three houses within a close proximity to each other in an urban area in County Kilkenny. Each house comprises of a sitting room, dining area, kitchen, bathrooms and individual resident bedrooms. The designated centre is staffed by a team leader, social care workers and health care assistants. 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:	8

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 7 December 2021	11:00hrs to 18:00hrs	Conan O'Hara	Lead
Wednesday 8 December 2021	15:00hrs to 18:00hrs	Conan O'Hara	Lead
Friday 10 December 2021	10:00hrs to 14:30hrs	Conan O'Hara	Lead
Friday 10 December 2021	10:00hrs to 14:30hrs	Conor Brady	Support
Friday 10 December 2021	10:00hrs to 14:30hrs	Leslie Alcock	Support

What residents told us and what inspectors observed

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

This was an unannounced inspection completed across the three premises that comprise this designated centre in Co. Kilkenny providing residential care to eight residents. Overall the inspection findings were very poor.

The inspectors were concerned on arrival to this centre that there was a complete absence of an appropriate management presence in the centre. This was found over the course of the inspection to be negatively impacting on the safety and quality of care delivered to residents.

On arrival to the designated centre, inspectors were informed the person in charge was on duty but the person in charge was actually on leave and the post of Chief Executive Officer (CEO) had also recently been vacated. There were no clear lines of authority and accountability present. A relatively new team leader was found to be providing full oversight of the care and support delivered in the designated centre. Staff on duty presented as unsure and unaware as to who was in charge within the service and expressed dissatisfaction with many aspects of how the service was being governed and operated. Inspectors found a complete deficit at management level in terms of oversight, monitoring and supervision of service delivery.

These governance failings were found to be having a direct and negative impact on the residents living in this designated centre. A safe and high quality service was not evident and this was attributable to a lack of an appropriate quality assurance systems to ensure the centre was at all times operating safely, appropriate to resident's needs, consistent and effectively monitored.

Inspectors met all of the residents present in the centre over the three days of inspection. Inspectors also met with members of the staff team. On the third day of the inspection (due to the levels of concern found), inspectors requested to meet with members of the board of management and the interim CEO.

Whilst the inspectors observed some positive findings for residents on this inspection the overall finding was that residents were not being appropriately supported in line with their assessed needs. All residents expressed their views verbally to inspectors. Residents spoken with noted that while they liked living in the houses, they were very unhappy with the staffing arrangements in place and outlined the negative impact on their daily life. For example, having their plans continually cancelled due

to an unplanned reduction in staffing levels.

Another resident was very upset and angrily stated that they would seek to leave Kingsriver services if the ongoing problems were not addressed shortly. In addition, the inspectors reviewed a sample of the complaints and compliments folder. Three resident complaints had been made in December 2021 in relation to the staffing arrangements in place and the negative impact of sudden changes in staffing on their daily lives.

In summary, based on what the residents communicated with the inspectors and what was observed, it was evident that the residents' received a poor quality of unstable care and support in this service. There were poor findings in relation to resident safeguarding, infection prevention control, staffing arrangements, staff training, supervision and development, resident assessment and support planning, fire safety and notification of incidents.

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, this inspection found that the registered provider had failed to demonstrate the provision of safe and quality care for the residents.

There was not an effective operational governance team in place whereby clear lines of authority and accountability were managing this centre.

Fundamental governance mechanisms were absent in this centre such as an 'on call' system, emergency cover, contingency management arrangements and basic staff support structures. Staff discussed being unable to contact managers, unable to take leave, being left in very difficult circumstances and in general being unsupported. A number of staff spoken with were relatively new staff members and reported an overall poor induction and experience of the service. Residents views gathered echoed these sentiments with irregular and inconsistent provision of staffing and an over reliance on agency staff evident.

There was a lack of an appropriate quality assurance system to ensure the centre was at all times safe, appropriate to resident's needs, consistent and effectively monitored. In addition, substantive improvements were required in staffing arrangements, staff training, supervision, rostering, staff support and development and the notification of incidents. The provider had not completed appropriate or satisfactory levels or standard of auditing and unannounced visits to ensure the centre was operating safely and in line with the regulations.

Immediate actions were issued by HIQA on the second day of inspection due to an

absence in assurance from the provider that appropriate governance and oversight would be in place for the coming weekend. Following this a response was provided highlighting increased staff and management oversight over the weekend period.

The significant governance deficits found by inspectors were discussed in detail on the third day of this inspection with representatives of the Board of the registered provider and interim CEO. It was clear that the board had recognised a number of the evident failings and organisational problems over the months prior to this inspection and were trying to implement some improvements. Some of these had been discussed and recorded at Kingsriver board meetings. However these discussions and efforts had unfortunately not translated into an improved and safe service for residents. The board stated that their priority was addressing the current issues and appointing a new CEO to ensure cohesive organisational strategic and operational objectives so that the service to residents would be improved

Registration Regulation 7: Changes to information supplied for registration purposes

The registered provider did not give notice to the Chief Inspector that the CEO had vacated their position within the organisation.

Judgment: Not compliant

Regulation 15: Staffing

Inspectors were concerned with the numbers and consistency of staffing provision in this centre. Of particular concern was the inconsistency of staffing and the impact this was having on support to residents. The provider used relief, agency staff and volunteers to achieve their staffing levels to provide supervision, care and support to residents. At the time of the inspection, the designated centre was operating with three whole time equivalent vacancies. The inspectors were informed a business case had been submitted to the provider's funder for additional staff. Based on the findings of this inspection this was required.

From a review of rosters, it was evident that staffing arrangements did not enable staff to plan their work and ensure a consistent level of care and support was provided to residents. For example, there were frequent staff changes in each house to ensure one unit remained appropriately staffed. This impacted on the other two units with evidence of an over reliance on agency/relief staff and of staffing levels falling below those required for assessed needs at times. As noted, the inspectors reviewed three recent complaints made by residents across two units on the negative impact of the inconsistency of staffing in their daily lives.

The inspectors reviewed a sample of staff files. The regulations require providers to obtain specific information on all staff and volunteers to ensure that they are

suitable to work in a designated centre. However, some files required review to ensure information on file was in place and accurate. Some staff information was found to be incorrect and some staff files had no evidence of two references as appropriate to ensure staff were suitably recruited.

Judgment: Not compliant

Regulation 16: Training and staff development

While there were systems for training and development in place further improvements were required. A staff training matrix was reviewed and a sample of staff training records and certification were inspected. While for the most part the staff team were up to date in mandatory training a number of staff required updated training in a number of areas including de-escalation and intervention techniques, infection prevention and control, manual handling and first aid.

From a review of supervision records, formal supervision and staff development was not occurring in line with the provider's policy. Inspectors found significant improvement was required in terms of staff support, development and appraisal. Issues such as staff rosters, leave, induction and ensuring appropriately experienced staff were in place required immediate review. Staff accessibility to management and meaningful supervision and support was needed in this centre.

Judgment: Not compliant

Regulation 23: Governance and management

There was an absence of operational governance found in this centre. There was not appropriate management arrangements or personnel in place over the three day inspection to ensure the service was operating safely. There was insufficient governance and oversight and an absence of effective quality assurances systems. No contingency plans were implemented nor was there a suitably appointed manager deputising for the person in charge. The inspectors were informed that there were no 'on-call' arrangements in place in the evenings and/or at weekends in order to support staff and ensure effective oversight of residents safety. Inspectors had to issue immediate actions to the registered provider to implement an interim 'on call' system to ensure oversight was in place so as the residents and staff had a manager available to them.

Overall there was an absence in basic management oversight which was compounded by the expressed dissatisfaction of residents and staff spoken with.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed a sample of incidents and accidents which occurred in the centre and it was not evident that all incidents were notified to the Chief Inspector in line with Regulation 31. For example, safeguarding notifications.

Judgment: Not compliant

Quality and safety

Overall the absence of effective governance and management had a negative impact on the quality of care and support received by residents. This inspection found that substantive improvements were required in resident safeguarding, fire precautions, protection against infection, positive behaviour support and personal assessment and support plans.

Inspectors found that systems in place to safeguard residents and ensure residents were appropriately supported in the areas of self care and protection were inadequate. For example, it was not evident that safeguarding plans were in place to manage an identified and ongoing safeguarding concern in the centre. This involved a resident who engaged in behaviours of concern that placed themselves and others at risk. Safeguarding incidents reviewed by inspectors indicated further assessment regarding the compatibility of residents living together needed to be undertaken. In addition, the inspectors reviewed a sample of safeguarding incidents and found that these incidents were not being managed or reported in line with the national policy for safeguarding vulnerable adults.

The systems in place for the prevention and management of risks associated with infection required improvement. While, the inspectors observed sufficient access to hand sanitising gels and personal protective equipment (PPE) throughout the centre, inappropriate use of masks by staff was observed on the day of inspection. In addition, it was not evident that the provider had prepared contingency plans for COVID-19 in relation to staffing and the self-isolation of residents in line with their infection control policy. Hence this centre was found to be ill-prepared in terms of their readiness to manage an outbreak.

Fire safety measures were found to require improvement. A fire door was found to be wedged open and fire detection systems and emergency lighting had no evidence of regular servicing.

The inspectors reviewed a sample of residents' personal assessments and plans. The

inspectors found that not all residents had an up-to-date comprehensive assessment of their health, personal and social care needs. This meant that the personal plans in place to guide staff in supporting residents with their assessed needs were not informed by a comprehensive assessment. There was an absence found in good quality, updated care planning guidance for staff to follow in terms of care provision. Given many staff spoken with were very new they were reliant on this information to be up-to-date and accurate.

Regulation 27: Protection against infection

The arrangements in place for the protection against infection required improvement. The providers infection control policy noted that plans were to be made for how the centre will manage COVID-19. However, on the days of inspection it was not evident that any contingency plans were in place for COVID-19 in relation to staffing and the self-isolation of residents.

All staff had adequate access to a range of personal protective equipment (PPE) and hand gels as required. Staff and resident temperature checks and cleaning schedules were in place. However, during the inspection, the inspectors observed that the staff use of face masks was not in line with public health guidance. Also, discarded face masks were observed in the front garden of one premises inspected.

Judgment: Not compliant

Regulation 28: Fire precautions

There was suitable fire equipment in place in the centre. However it was not evident that all fire equipment was serviced as required. For example in all three units it was not evident that the emergency lighting had been serviced quarterly. In addition, in two units it was not evident that the fire alarm had been serviced on a quarterly basis.

Inspectors found that improvement was required in the fire safety arrangements. For example, the inspectors observed the fire door to the staff office in one unit to be wedged open on two days of the inspection. This was identified to the team leader on both days of the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed a sample of resident's personal plans and found that improvement was required in the comprehensive assessment of needs. For example, from the sample reviewed, the assessments in place did not comprehensively assess the residents' health, personal and social needs. In addition, one resident's assessment of need was dated 2019. This meant that the personal plans in place were not informed by a comprehensive assessment and did not appropriately guide staff in supporting residents.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Improvements were required in the systems in place to support residents to manage their behaviours. While residents appeared to have some access to an internal behaviour specialist, improvements were required to ensure staff had access to up-to-date information to respond to behaviour and support residents to manage their behaviour. For example, on the first two days of inspection, a behaviour support plan for one resident was not available. Staff knowledge was found to be limited in this area. While this plan was located by the third day of the inspection it had not been available to guide the staff team to support a resident with complex behavioural needs.

Judgment: Not compliant

Regulation 8: Protection

Inspectors were not satisfied that safeguarding arrangements were appropriately robust. There were not suitable safeguarding plans in place to guide staff on managing safeguarding concerns and residents who engaged in high risk behaviours. The inspectors reviewed a sample of incidents and accidents occurring in the designated centre and found that all safeguarding concerns were not reported in line with the national policy for safeguarding vulnerable adults. Furthermore a safeguarding review of resident compatibility is required given the frequency and type of incidents occurring between residents in one unit of this centre.

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 7: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Court - Kingsriver OSV-0007915

Inspection ID: MON-0031980

Date of inspection: 07/12/2021 08/12/2021 10/12/2021

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**
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: 1.The Interim Manager filed notification NF033A on the 12th January 2022 notifying the Authority that the CEO vacated their position within the organisation. Confirmation received of filing from the Authority on the same day.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1.a 1 full time Social Care Worker commenced employment on the 28th December 2021. 1.b 1 full time Healthcare Assistant commenced employment on the 10th January 2022. 1.c 1 agency staff was engaged on a full-time line for a 3-month period on the 12th January 2022. 1.d Recruitment of staff is ongoing. 2. The filling of the above positions has reduced the need for staff rotation in houses. 3. An Audit of staff files has commenced and will be completed on the 25.1.2022. Follow up actions will be taken to address deficits identified from this audit by the 31st March	

2022.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. A Training Needs Analysis was completed on the 2nd January 2022. Mandatory training required has been identified and training has been scheduled for the first quarter of 2022. Training will be scheduled on a quarterly basis thereafter.

2. All mandatory staff training to be completed by the 20th March 2022, and ongoing thereafter in line with new staff joining.

3. External supervision training has been scheduled for Team Leaders for the 14th February 2022.

4. A supervision schedule has been put in place for all staff. All staff have been scheduled to have an initial supervision session completed by the 28th February 2022.

5. Monthly staff meetings have been put in place from December 2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. A Governance chart was put in place in each location on the 12th January 2022, which clearly outlines operational governance structures.

2.a An emergency on-call system was put in place on the 9th December 2021.

2.b An on-call rota was implemented on the 9th December 2021.

2.c The Interim Services Manager wrote to all on-call managers on the 9th December 2021 providing them with clarity on who they should contact in the event of requiring advice / support in an emergency.

2.d A document was sent to all staff in each House on the 9th December 2021 clarifying

what constitutes an emergency, where the on-call person should be contacted.

2.e A log was implemented on the 9th December 2021 for on-call activity from a governance oversight perspective.

2.f A monthly on-call roster is now in place.

3. The Person in Charge has implemented weekly team meetings with Team Leaders with effect from the 5th January 2022, with a focus on oversight and management of core issues including complaints, incidents, medication errors, safeguarding, training and rotas.

4. Monthly staff meetings have been put in place from December 2021.

5. Training was provided to the Board of Directors on the Health Act (2007) and associated regulations, including their responsibilities as Registered Provider, on the 10th January 2022. Further training will be completed by the 28th February 2022.

6. A schedule of audit has been completed and commenced on the 27th December 2021.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. The notifiable incidents in question were reported to the Authority on the 20th December 2021.

2. Incidents are being reviewed on a daily basis by a member of the management team.

3. The Person in Charge is reviewing all incidents with Team Leaders on a weekly basis.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1.a A Covid Response Plan to guide staff was put in place on the 12th January 2022, in each house.

1.b A Covid Preparedness and Emergency response plan to guide managers was put in place on the 12th January 2022.

1.c An individual outbreak plan will be put in place for each resident by the 26th January 2022.

2.a Infection, Prevention and Control audits commenced on the 27th December 2021.

2.b Infection, Prevention and Control training will be completed by all staff by the 25th January 2022.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1.a The fire equipment servicing schedule has been reviewed The fire alarms are scheduled for service on the 25th January 2022.

1.b Emergency Lighting Servicing is scheduled for all residential locations on the 25th January 2022 and quarterly thereafter.

2. An email was sent to all staff on the 10th January 2022 to instruct them that fire doors were not to be wedged open and this issue is being monitored by managers on their visits to the Centre.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. A review of all individual assessments and personal plans has commenced and these will be completed / updated by the 21st March 2022.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1. All stress (behavioural) support plans have been updated and are fully available to staff. 2. A stress (behavioural) support plan management system was implemented on the 18th January 22. 3. Positive Behavioural Support training for staff has commenced on the 14th January 2022 and will be completed for all existing staff by the end of March 2022.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: 1. The safeguarding incidents were subsequently reported to the H.S.E Safeguarding Team on the 21st December 2021. 2. The Person in Charge met with the H.S.E. Safeguarding Lead for CHO5 on the 4th and 5th January 2022 to review all safeguarding referrals and plans. 1. Updating of safeguarding plans has commenced and will be completed by the 7th February 2022, and ongoing thereafter. 2. Safeguarding training was completed for all outstanding staff on the 7th January 2022. 3. Additional staff resources were put in place on the 17th December 2021, from a safeguarding / compatibility perspective. 4. Staff will support residents in their understanding of safeguarding through the use of easy read resources, by the 7th February 2022.	

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
Registration Regulation 7(4)(a)	The registered provider shall give not less than 8 weeks notice in writing to the chief inspector if any of the following is proposed to take place: (a) where the registered provider is a body corporate (whether a natural person, a company or other corporate body), there will be any change to: (i) the ownership of the body (ii) the identity of its director, manager, secretary, chief executive or any similar officer of the body (iii) the name or address of the body and shall supply full and satisfactory information in regard to the matters set out in	Not Compliant	Orange	12/01/2022

	Schedule 3 in respect of any new person proposed to be registered as a person carrying on the business of the designated centre under (a), (b) or (c).			
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	12/01/2022
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.	Not Compliant	Orange	12/01/2022
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/03/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	20/03/2022

	have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	28/02/2022
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.	Not Compliant	Orange	17/12/2021
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	Red	09/12/2021
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	Not Compliant	Orange	23/02/2022

	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.			
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	26/01/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	25/01/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	25/01/2022

	detecting, containing and extinguishing fires.			
Regulation 31(1)(f)	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 allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	20/12/2021
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	21/03/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	21/03/2022
Regulation 07(1)	The person in charge shall ensure that staff	Not Compliant	Orange	31/03/2022

	have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	07/02/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	07/02/2022