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:	Hall Lodge
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	07 December 2022
Centre ID:	OSV-0001709
Fieldwork ID:	MON-0038567

About the designated centre

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

Hall Lodge is a designated centre operated by Sunbeam House Services CLG. Hall Lodge provides residential care and respite for adults who are over the age 18 years. Hall Lodge supports people who have severe and profound learning disabilities and medical issues. Some residents also have a physical disability. Hall Lodge aims to empower people with the necessary skill to live full and satisfactory lives as equal citizens of their local community. Hall Lodge comprises three properties. The centre is managed by a person in charge who reports to a senior services manager.

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
Wednesday 7 December 2022	10:20hrs to 17:35hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out in response to solicited and unsolicited information received by the Chief Inspector in November 2022.

The information included a notification of a serious incident that occurred in the designated centre, and unsolicited information that outlined concerns about the provider's ability to appropriately manage the centre and respond to concerns, staffing levels, and the general quality and safety of service provided to residents in the centre.

The centre was registered to accommodate a maximum of four residents and comprised of three separate residential properties. On this inspection, the inspector visited all three properties which made up the designated centre.

The main building, intended as a respite service, comprised several bedrooms, bathrooms, a spacious kitchen, and large open plan living area. The open plan living area was decorated with a Christmas tree and decorations, and was found to be homely and comfortable. The bedroom for the full-time resident was observed to be nicely decorated and maintained.

However, due to the layout and size of the building, parts of it remained institutional in aesthetic. Maintenance and upkeep was required in the building, for example, there was rust on some radiators, flooring was damaged in areas, kitchen counters were damaged, and sofa fabric was torn. The inspector also noted some of the fire containment arrangements in this property were poor, and these matters are discussed further in the report.

The adjoining single occupancy apartment comprised of a resident bedroom with ensuite bathroom, a small staff office with en suite bathroom, kitchen/dining room and sitting room The apartment was not in a good state of repair. Re-painting was required throughout, and some of the flooring, walls and skirting boards were marked and damaged. For example, there was a hole in the wall in the kitchen dining room.

Other areas also required addressing, for example, the inspector observed damaged curtain poles, and exposed wires in the staff room. The hand washing facilities also required improvement as in some of the bathrooms there was no paper towels to dry hands and the waste receptacles were not appropriate. The premise issues had been previously reported by the person in charge, and some issues were being addressing by the provider's maintenance department during the inspection, for example, the hole was being repaired.

The second property was unoccupied at the time of inspection. It consisted of a one bedded building also located on the provider's campus setting. The third property was also unoccupied and consisted of a single-storey building located in a housing

estate in a small town.

In preparation for the planned renovation works of the main property, these buildings had been upgraded to accommodate residents, for example, there was new flooring and furniture in place with some intended further upgrades required but not completed. As discussed, due to resourcing constraints these properties remained vacant and were not being used for their intended purpose which was to accommodate residents while the main property and apartment were upgraded.

The inspector met both residents living in the centre. They did not verbally communicate their views with the inspector, but the inspector observed staff engaging with them in a kind and respectful manner. The last annual review of the care and support provided in the centre, carried out in July 2022, had consulted with residents. One resident reported that they did not like the location of their bedroom. This was due to be addressed as part of the renovation works of the centre.

As a result of staffing shortages, the person in charge, on the day of inspection, had assigned themselves to support residents. However, they made alternative arrangements so that they could facilitate the inspection.

The person in charge demonstrated a very good understanding of the residents' care and support needs, and spoke about how they endeavoured to ensure that residents received a safe and quality service. They told the inspector about the ongoing challenges in securing consistent staff to work in the centre, which was adversely impacting on the residents and permanent staff. The person in charge had escalated their concerns regarding staffing to senior management. The inspector viewed recent staff rotas with the person in charge, and found that overall the staff arrangements were inadequate. These matters are discussed further in the report.

Staff working in the centre spoke with the inspector. They spoke about residents in a dignified and respectful manner, and express concerns regarding insufficient staffing and high use of agency workers in the centre. They told the inspector that these issues had led to increased pressure, low staff morale. They spoke about how they endeavoured to minimise any potential impact on residents, however at times this was unavoidable. For example, recently a resident's social activity did not take place as planned, and a resident went to bed earlier than usual due to the staffing arrangements. They also expressed concerns that the living environment was not suitable for the residents due to noise levels between the apartment and main building which could impact on both residents.

They told the inspector about the activities residents enjoyed such as walks, drives, equine therapy, cinema, bowling, and dining out. During the inspection, residents were supported by staff to go for walks and drives. They had no safeguarding concerns, and were familiar with the residents' positive behaviour support plans and strategies, and the procedures for reporting incidents. They felt comfortable raising concerns, however advised the inspector that issues previously raised remained unresolved, for example, staffing levels.

From what they were told, read, and observed during the inspection, the inspector found that overall, there were significant deficits in the quality and safety of service

provider to residents in the centre due to the provider's ability to adequately resource the centre.

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

Capacity and capability

The inspector found that the provider's governance and management systems and arrangements were required improvement to ensure that the service provided to residents in the centre was suitably resourced to ensure it was safe, consistent or appropriate to their needs.

The registered provider had not ensured that the designated centre was resourced to ensure the effective delivery of care and support to residents. As a result this inspection found high levels of non compliance which were attributable to the ineffective resourcing arrangements of the provider.

The primary property was a large single storey building located on a campus based setting operated by the provider. This property was intended to provide respite services but was, at the time of inspection, accommodating one resident in a full-time residential capacity. A separate self-contained apartment, adjoined to this building, accommodated another full-time resident who required a single occupancy living arrangement.

The respite service had ceased operating during the COVID-19 pandemic and had not yet resumed. In June 2022, the provider applied to increase the footprint of the overall designated centre to include two additional properties thereby increasing the number of units under the footprint from one to three.

At the time, the provider had planned for the full-time residents to temporarily move to these two separate homes while renovations works of the main property were undertaken in quarter three of 2022. However, the renovation works have been postponed indefinitely due to resourcing issues.

The staffing arrangements were inadequate and impacted on the quality and safety of service provided in the centre. There were frequent occasions when actual staffing levels were below planned levels. Although the provider was actively recruiting to fill vacancies, the reliance on agency staff provided by an external agency to operate the service, did not ensure consistency of care and at times adversely impacted residents.

Managing the staffing levels also required significant time and attention from the person in charge as they were required to engage in frequent communication with external staffing agencies to source agency workers to cover shifts in the centre. At

times the person in charge assigned themselves to work shifts which further impacted on their management and oversight duties and responsibilities. In addition, regular staff working in the centre told the inspector that the ongoing staffing challenges were causing them to feel stressed and pressurised.

The centre required renovation and upkeep. While the provider had planned to renovate the centre in quarter three of 2022, these works had been indefinitely postponed until the provider had secured the required funding and staffing arrangements to facilitate the renovations.

There was a clearly defined management structure in the centre. The person in charge was full-time, and they were supported by a deputy manager in the management of the centre. They worked mostly on alternate days to ensure consistent management presence in the centre. The deputy manager post was due to be vacant by the end of the year, and the provider was recruiting to fill it. The person in charge reported to a senior manager who in turn reported to the chief executive officer.

There were good arrangements for the management team to communicate and escalate concerns, for example, the person in charge had escalated their concerns regarding staffing levels in the centre to the senior manager and provider’s human resource department. The concerns also highlighted the risk of failure to comply with regulations due to the resource issues. The senior manager responded by arranging meetings with the person in charge and staff team, and escalated the concerns to the chief executive officer. Overall, the person in charge and senior manager were found to be responsive to the needs' of the residents, and endeavoured to ensure that the service provided to them was appropriate but were constrained by the resources available to them.

There were arrangements for staff to raise concerns about the quality and safety of care and support provided to residents. Staff told the inspector that they were comfortable raising concerns with the person in charge and management team. Outside of normal working hours, staff could utilise an on-call system. Staff also attended monthly meetings. The meetings minutes from November 2022 noted discussions on how to contact management during weekends, and staff concerns regarding unfamiliar staff working with residents. There had also been recent meetings with staff, management, members of the provider's multidisciplinary team, and human resource department for staff to further discuss their concerns.

While a suite of local audits had been carried out to identify areas for improvement, overall the provider's systems for monitoring the centre required improvement. The recent unannounced report on the quality and safety of care and support in the centre provided insufficient information on the areas identified for improvement, and the annual review did not reflect any consultation with residents' representatives.

Regulation 15: Staffing

The registered provider had not ensured that the number of staff working in the centre was appropriate to the number and assessed needs of the residents. There were several vacancies at the time of inspection, some of which were due to long-term sick leave. The provider was actively recruiting for the vacancies, however had not been fully successful.

The provider used its own staff along with agency staff to fill some of the vacant shifts. The person in charge was also required at times to fill vacant shifts which had the potential to impact on their ability to fulfil their primary role, for example, they had been unable to attend a resident's recent appointment.

The reliance on agency staff to operate the service did not ensure that residents received continuity of care and support. Furthermore, the arrangements for inducting agency staff on the residents' care and support needs required improvement as there were no documented records in the centre to indicate that they had received induction.

The person in charge maintained planned and actual rotas. The inspector viewed the planned staff rotas from October, November and December 2022 which indicated that there should be three staff on duty during the day times. The actual staff rotas showed frequent occasions when there was only two staff on duty. The inspector found that the rotas were not properly maintained, for example, not all codes not clear, some handwritten amendments were illegible, and the full names of staff were not always recorded.

The low staffing levels and reliance on agency staff had adversely impacted residents, for example, a recent activity did not happen as planned, and a resident went to bed earlier than usual due to the staffing arrangement. Complaints had been made by residents and their representatives in relation to the ongoing staffing issues.

Judgment: Not compliant

Regulation 23: Governance and management

There was a defined management structure in place with clear roles and responsibilities outlined. Overall it was demonstrated that the person in charge and senior manager were endeavouring to ensure that the service provided to residents met their needs. However, the registered provider had not ensured that the centre was resourced to ensure the effective delivery of care and support to residents.

As noted under Regulation 15: Staffing, the staffing arrangements were inadequate, and as noted under Regulation 17, the premises were not suitable to meet the full needs of all residents and required renovation; the provider had failed to put in place the required human and financial resources to address these matters.

The management systems, to ensure that the centre was safe, effective, and

consistently monitored required improvement.

The recent provider-led unannounced report on the quality and safety of care and support provided in the centre was not dated or signed, but appeared to have been carried out in September 2022. The provider-led report was very limited in detail, for example, it noted "significant staffing issues" and issues with the fire equipment, however offered no further information on these matters. Therefore, it was unclear if the provider was being fully informed of the non compliance and level of risk occurring in the centre.

The inspector was informed that the provider's annual review had consulted with residents and that there had also been consultation with residents' families, however family consultation information had not been included in the annual review or any other documentation reviewed by the inspector.

Judgment: Not compliant

Quality and safety

The inspector found that the quality and safety of the service provided in the centre to residents required improvement in the areas of risk management, protection, fire precautions, and premises.

The two properties that had been recently added to the centre's footprint to temporarily accommodate residents to facilitate renovation works in the main property had received some upgrades in order to be suitable to accommodate residents, however, at the time of inspection, these properties were vacant as the planned renovation works were suspended. In addition, the inspector found that the properties would require further upgrades of the fire safety systems before residents could be accommodated, for example, more fire extinguishers would be required.

The main property was located on the provider's campus. It accommodated one resident in a self contained apartment, and one resident in the main building that was intended for providing respite services. The premises required upkeep and renovation throughout. Parts of it had been nicely decorated, however, aspects remained institutional in aesthetic due to the size and layout of the building.

The arrangements for containing fires were inadequate and posed a risk to the safety of residents. Some of the fire doors tested by the inspector did not close properly. While most were fixed during the inspection, one remained broken. The inspector also observed some fire doors being wedged open which compromised the integrity of the fire safety measures. The inspector observed the person in charge remove the wedges when these matters were brought to their attention.

The provider had prepared a written risk management policy, and there were arrangements for the assessment, management, and escalation of risk. The person

in charge had completed risk assessments on the risks presenting in the centre, and escalated serious risks to senior management. The controls for some of the serious risks included staff training. However, training records were not made available to the inspector during the inspection, therefore it was unclear if these risk control measures were suitably in place.

The registered provider had not ensured that the systems in place for responding to risk were sufficient in relation to behaviours of concern displayed by residents. Further documented guidance was required to guide staff on responding to incidents and monitoring residents any for injuries.

Recent staff meeting minutes included discussions on incidents, and the arrangements for recording incidents. Incidents were recorded on an electronic data system. However, agency staff could not access the system and completed handover sheets instead. The inspector found that recent handover sheets had not been completed and therefore the provider could not provide assurances that all incidents were being reported. However, there were good arrangements for the person in charge and senior manager to review reported incidents to identify potential learning to reduce the likelihood of incidents recurring.

The registered provider had arrangements in place to protect residents from abuse. The inspector found that safeguarding concerns were reported and managed appropriately. Staff had access to safeguarding information and resources. However, the safeguarding training records were not made available to the inspector as requested, and therefore it was not demonstrated that all staff had completed training in this area.

Regulation 17: Premises

The provider had not ensured that the centre met the full needs of residents, and that it was kept in a good state of repair.

The provider had planned to renovate and reconfigure the premises, in the third quarter of 2022, in order for it to meet the needs of the residents. However, the plans were delayed indefinitely due to issues sourcing the required staff arrangements and funding to facilitate the works.

Some residents reported as part of the annual review that they were unhappy with the location of their bedrooms, and this matter had not been addressed.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had prepared a written risk management policy, dated August 2020, that outlined the arrangements for the assessment and management of risk. The person in charge demonstrated a very good understanding of the risks presenting in the centre and had completed corresponding assessments on risks including staffing shortages, and behaviours of concern displayed by residents. The inspector found that the risk assessments were appropriately rated and included measures to control the risks.

The controls in place for some of the serious risks included multidisciplinary team support and input, and staff training. However, staff training records were not made available to the inspector as requested to demonstrate that staff have the skills to appropriately support residents and reduce associated risks. The person in charge escalated serious risks to the senior manager, who in turn escalated them to the provider's corporate risk register for further attention.

The registered provider had not ensured that the systems in place for responding to risk in relation to behaviours of concern displayed by residents were sufficient. Behaviour support plans were available to guide staff on responding to these behaviours, however there was no documented guidance on managing behaviours in the car which was a common occurrence. Furthermore, the emergency guidance in responding to these types of incidents required consolidation and alignment to ensure that staff had appropriate guidance on responding to emergencies and on monitoring residents' for injuries following incidents of self-harm, particularly head injuries.

Incidents were recorded by the provider's staff on an electronic data system. Agency staff could not access the system and completed handover sheets. However, the inspector found that recent handover sheets had not been completed and therefore the provider could not provide assurances that all incidents were being reported and thus appropriately managed.

The person in charge reviewed all of the recorded incidents which occurred in the centre to identify potential learning to reduce the likelihood of incidents recurring. The senior manager also reviewed the incidents to demonstrate their oversight of the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not ensured that there were adequate arrangements for the containing of fires which posed a risk to residents' safety.

The arrangements for the operation and maintenance of fire doors was poor. While some doors were fully operational and closed properly when released, the inspector found that some doors did not close properly or were broken which compromised their effectiveness in containing smoke or fire. Some of the fire doors were fixed

during the inspection, however one remained broken. The inspector requested that measures were put in place to mitigate this risk, and the person in charge responded by putting up signage and issuing notices to staff.

The inspector observed some fire doors that were wedged open which compromised their effectiveness. The person in charge removed the wedges during the inspection.

Judgment: Not compliant

Regulation 8: Protection

While the registered provider had established arrangements to protect residents from abuse, it was not clear if all of the arrangements were in place.

Staff working in the centre were required to complete training in relation to safeguarding residents and the prevention, detection and response to abuse appropriate.

However, the training records were not made available to the inspector as requested, and therefore they were not assured that all staff had completed training.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Hall Lodge OSV-0001709

Inspection ID: MON-0038567

Date of inspection: 07/12/2022

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The current staffing requirement for the centre without supporting respite is 15.39 WTE, the centre currently has 12.37 WTE hours available on the roster through staff contracts. The centre has successfully recruited staff for posts in Dec and Jan and one new hire is due to start. Any open shifts will be endeavoured to be filled by regular staff or regular agency staff who have been inducted into the centre. There is an active recruitment campaign ongoing to fill outstanding roles. Since the return of residents to the one centre there has been a decrease on reliance of agency staff to fill the roster. In October, 9% of shifts were covered using Agency staff in November is reduced to 4%. There is an induction process in place for new staff and for shorter term staff, all agency staff currently working at the centre have now completed this induction. The PIC has laminated the roster to prevent others from making changes, there is a record sheet in place to record any changes to the roster and the PIC will reflect and update the roster with these changes, this will ensure the roster remains clear to read.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The current staffing requirement for the centre without supporting respite is 15.39 WTE, the centre currently has 12.37 WTE hours available on the roster through staff contracts.	

The centre has successfully recruited staff for posts in Dec and Jan and one new hire is due to start.
Any open shifts will be endeavoured to be filled by regular staff or regular agency staff who have been inducted into the centre.
There is an active recruitment campaign ongoing to fill outstanding roles

The providers Annual Review has been reviewed to ensure it includes relevant level of detail, dated and signed.

The providers maintenance team action maintenance issues timely at this centre, however, due to the nature of some incidents damages occurs regularly, any damages repairs are logged on the providers database and actioned in accordance to priority.

Renovations were planned to the centre to expand to accommodate the delivery of respite. These renovations have been delayed. The PIC will consult with the resident in relation to their will and preference about moving bedrooms and put a plan in place.

All fire doors will be serviced and repairs will be carried out where needed.

The PIC has provided written direction to all staff not to use door stoppers to keep doors open. This will be further discussed at the upcoming staff meeting.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider had planned to renovate and reconfigure the premises, in the third quarter of 2022 in order for it to meet the needs of the residents and deliver respite services. However, the plans were delayed due to issues sourcing the required staff arrangements and funding to facilitate the works. The Provider is liaising with their funders in relation to future plans.

Any repairs to the centre will be logged on the providers maintenance database and will be actioned in accordance to priority.

The PIC will consult with the resident in relation to their will and preference about moving bedrooms and put a plan in place.

Regulation 26: Risk management	Not Compliant

procedures	
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Staff training records are currently being updated for the current year, staff will be booked for any outstanding training. The Positive behaviour support plan for one resident will be finalized and will include how to support the client while out in the car, the Behaviour Support Specialist will meet with staff team to provide guidance and details of the delivery of the positive behaviour support plan. Staff are trained in first aid which provides guidance on monitoring residents' for injuries following incidents of self-harm, particularly head injuries. The PIC will implement a guidance sheet for one residents personal plan in relation to this. There is currently a facility on the Providers database to add agency staff to allow them to record their handover. Regular agency staff have been added to the database and new staff can be added when needed.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The PIC has provided written direction to all staff not to use door stoppers to keep doors open. This will be further discussed at the upcoming staff meeting. Door closures have been ordered and expected delivery date 30/01/2023.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The training calendar will reviewed and all staff will be booked for any outstanding training.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2023
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	11/01/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	11/01/2023

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/01/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	28/02/2023
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	30/06/2023
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	Substantially Compliant	Yellow	28/02/2023

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/01/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	30/01/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Not Compliant	Orange	30/01/2023

	ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	11/01/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	14/02/2023
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	30/01/2023