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:	Coolmine Court - Community Residential Service
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 15
Type of inspection:	Announced
Date of inspection:	28 October 2021
Centre ID:	OSV-0003074
Fieldwork ID:	MON-0026814

About the designated centre

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

Coolmine Court is two adjoining two-storey houses that are connected internally by a door located in the front hallway. There is a total of 8 bedrooms, 1 bedroom is being utilised as a staff office and bedroom. There is a large back garden and shared front driveway. The team in Coolmine Court provides full time, low to medium support residential care to 7 female residents. The ladies also have varying health care needs. The team in Coolmine Court consists of one clinical nurse manager, two full time staff nurses, one part time nurse, three social care workers, and health care assistants. Staff nurses are rostered daily to support service users medical needs. The care provided in the centre is based on Roper, Logan and Tierney's model of care. The centres Statement of Purpose states: it is the mission of Coolmine Court to provide a person centred and safe home to the service users.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 28 October 2021	09:30hrs to 16:30hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and as such , the inspector followed public health guidelines such as wearing PPE and maintaining social distance. From what residents told the inspector, reviewing documentation and observing daily routines, it was clear that residents were enjoying a good quality of life and that their health and social care needs were being safely provided for.

This centre is home to seven residents who are ageing and in active retirement. The inspector met and spent time with each of the seven residents during the day. All of the residents used speech to communicate, with two of them requiring some support from staff to contextualise specific phrases which they used. Residents enjoyed a range of activities, particularly knitting and crafts and much of their artwork was displayed on the walls and the mantelpiece of each house. Prior to the COVID-19 restrictions, some of the residents attended day services. This was due to resume in the weeks shortly after the inspection. Staff had endeavoured to provide activities for residents during the period of restrictions by doing baking, going for walks, enjoying the garden and some residents had enjoyed online activities such as bingo. All residents had purchased a tablet and enjoyed using them to take photographs, speak with family members, do jigsaws and word searches and to watch videos. One of the residents showed the inspector their smart watch which they were counting steps on. This was also used as an alarm to remind them to do different tasks during their day which promoted their independence.

There was a culture of promoting residents' rights and listening to their concerns in the house. This was evident from speaking with residents and staff and documentation of complaints and residents meetings. One of the residents asked to speak with the inspector. They told the inspector that they had made a complaint and this had been listened to, investigated and resolved. They went out with their key worker for their scheduled one to one time in the afternoon which they reported that they really enjoyed.

All of the residents had completed a questionnaire which had been circulated to the person in charge in advance of the inspection. The questionnaire seeks feedback on a number of areas such as overall satisfaction with the service, their bedroom, mealtimes, staff support, rights and complaints. Residents spoke with the inspector on an individual basis with their questionnaires. Overall, residents reported that they were happy in the centre. They reported to enjoy activities such as karaoke, flower arranging, baking, arts and crafts, one to one time with their key workers , going shopping and watching movies. One of the residents raised concerns about use of relief staff. Another raised concerns about their bedroom not having enough space for their belongings. Another resident reported that they had difficulty with another resident disturbing them when they were watching television. These concerns had all been logged as complaints prior to the inspection and were actioned.

In summary, it was evident to the inspector that residents were well cared for in their home. They all reported feeling happy and safe. Most importantly, they reported that their voice was heard when they did have a concern or complaint to make. There was a relaxed atmosphere in the house and the inspector noted residents were comfortable in the presence of staff. Interactions were noted to be kind and respectful. The next two sections of this report will present the inspection findings in relation to the governance and management in this centre and how governance and management arrangement affects the safety and quality of the service being delivered.

Capacity and capability

The provider had good management systems and processes in place to ensure that residents were receiving a safe , good quality service. There was a clear reporting structure, with the person in charge reporting to the Clinical Nurse Manager. There were emergency governance arrangements in place and the provider had set up a serious incident management team to provide leadership and management throughout the COVID-19 pandemic. The provider had a number of committees in place to ensure oversight of a range of areas relating to residents care such as a quality and risk committee, a restrictive practice and ethics committee and a health and safety committee.

However, annual reviews and six monthly unannounced visits which are required under regulation 23 required improvement. The provider had carried out a comprehensive annual review for 2020 and this was done in consultation with residents and their families. Feedback was largely positive, with maintenance being the only reported concern. Six monthly unannounced visits for 2020 were not done in line with the regulations. The visit in July did not occur. However, the provider had carried out a remote review of practices. Visits to the centre from senior management were reportedly carried out in the garden and support was provided by telephone from March 2020 and in house visits had resumed in April of 2021.

Day to day oversight of the centre was provided through weekly audits carried out by staff. These were reviewed by the person in charge who compiled a quartlery report on all findings and associated actions which they shared with senior management. Staff meetings were found to have a set agenda and structure.These included learning from any adverse events, safeguarding and rights, quality and policy updates. The person in charge attended regular management meetings. There were appropriate arrangements in place for staff supervision and performance management. This had been updated since the last inspection. Staff had signed supervision agreements in place and received supervision from the person in charge twice a year. The person in charge was supervised by their line manager regularly.

The provider had appointed a suitably qualified and experienced person in charge. The inspector found the person in charge to be very knowledgeable about the

residents and their needs and had good systems of documentation and monitoring in place to ensure oversight of the centre. The person in charge was on the roster and had very little time allocated to them to complete managerial tasks required by a person in charge. It was noted on the day of the inspection that the provider had increased the person in charge's hours to do managerial tasks. However, this arrangement continued to require the person in charge to work shifts and at times, to do extra hours to fulfill their duties.

The provider had a suitable number of staff with the required skills in place to ensure that the residents' health and social care needs were met in both houses. The inspector viewed the planned and actual rosters. These indicated that where relief or agency staff had been required, there was no continuity in the staff members used to cover shifts. For example, in the four weeks which the inspector viewed there was a total of seventeen different relief staff in the house. This did not promote continuity of care for residents. Additionally, this posed a potential risk for exposure to COVID-19 due to increased foot fall in the centre. Staff training had improved since the last inspection, with all staff in date for mandatory training in areas such as fire safety, safeguarding and manual handling . The person in charge had set up a house folder and checklist for any relief or agency staff on their first shift.

The inspector found that all notifications had been submitted to the Office of the Chief Inspector in line with regulatory requirements. Complaints and concerns were found to be promoted and there was an open culture in the house. The inspector viewed the complaints log, residents meetings and documentation relating to specific complaints. These indicated that where a complaint was received that the staff and the person in charge documented it appropriately and more importantly worked to resolve the issue at local level and elevate it where required in line with the provider's policy.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted all required information for the application for renewal of the centre's registration.

Judgment: Compliant

Regulation 14: Persons in charge

The provider appointed a suitably qualified and experienced person in charge and met the requirements of regulation 14.The inspector found the person in charge to be very dedicated to the role, with good systems in place and they were knowledgeable about each resident and their assessed needs.

Judgment: Compliant

Regulation 15: Staffing

The provider had a suitable number of staff with the required skills in place to ensure that the residents' health and social care needs were met in both houses. The inspector viewed the planned and actual rosters. These indicated that there was a relatively stable staff team in place and that staff had covered extra shifts where appropriate. However, where relief or agency staff had been required, there was no continuity in the bank of staff used. For example, in the four weeks which the inspector viewed, there was a total of seventeen different relief staff in the house. This did not promote continuity of care for residents and posed potential risk for exposure to COVID-19 due to the footfall in the house.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff training records indicated that all staff had completed mandatory training in manual handling, fire safety, safeguarding and a number of courses relating to infection prevention and control such as hand hygiene, breaking the chain of infection and donning and doffing of personal protective equipment. In order to support continuity of care and safe practice for agency or relief staff, the person in charge had developed a 'house folder' which had key information about the house and the residents. Care plans were done using a traffic light system to ensure that key information was easily accessible to all staff. There were also detailed house routines and shift planners for days of the week. Staff on duty on the day of the inspection reported that they felt well supported in their roles and enjoyed working in the house.Supervision had improved since the last inspection. Staff received supervision twice a year from the person in charge and there was a structured agenda in place for these sessions. There was an annual performance review carried out with staff. The person in charge met with their manager once a quarter.

Judgment: Compliant

Regulation 23: Governance and management

The provider had a clear reporting structure in place and a number of systems and processes to ensure that residents were receiving good quality care. The provider had carried out an annual review for 2020 and this was done in consultation with

residents and their families. There were clear and time bound actions arising from this review and many of them had been actioned on the day of inspection. However, six monthly unannounced visits did not take place as required by the regulations. The provider had done an audit remotely but no unannounced visit had taken place. No annual review was carried out in 2019.

Oversight at centre level was provided through weekly audits and quarterly reviews by the person in charge. The person in charge was required to work shifts and did not have adequate time to fulfill their duties, requiring them to work additional hours. The staffing arrangements for relief staff were such that continuity of care was not promoted.

Judgment: Not compliant

Regulation 3: Statement of purpose

The centre's Statement of Purpose contained all information required by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

All notifiable events were notified to the Office of the Chief Inspector within required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy in place with the process for raising concerns or complaints regularly communicated with residents. The inspector found there to be an open culture in the centre which promoted residents' rights and dealt with complaints appropriately in line with the provider's policy.

Judgment: Compliant

Quality and safety

The inspector found that residents in the centre were actively supported to pursue their interests and that their health and social care needs were met. They were well presented and reported to be happy. Each resident had an annual review of their needs and there were corresponding care plans in place. Residents also had retirement plans in place which were person centred and had photographic evidence of residents achieving their goals and pursuing their interests. Residents had a 'bucket list' of activities and items they would like to do. Each resident's retirement plan was reviewed with them on a monthly basis. Care plans were clearly laid out using a traffic light system to ensure that highly important information was communicated to all staff effectively. Care plans were reviewed on an annual basis or sooner where needs changed. There was evidence of input from a multidisciplinary team where this was appropriate.

Residents were supported to enjoy best possible health. This was a nurse led service and each resident had very clear health care plans in place. Residents attended a local GP and had an annual medical review carried out. Residents had access to a range of health and social care professionals including psychiatry, a clinical nurse specialist in dementia, dentistry, dietetics and occupational therapy. Daily observations were carried out and documented clearly. The centre was able to access all results from tests residents had attended through an online system. All of the residents had been supported to develop an end-of-life care plan with their wishes documented. These were primarily related to the resident's preferences around funeral arrangements and personal possessions rather than care preferences but were very person -centred. Hospital passports were in place.

The provider had good systems in place to ensure residents were protected from all forms of abuse. They had a policy which outlined staff responsibilities in relation to safeguarding and this was in line with national policy. Any safeguarding incidents were found to be documented, reported and investigated appropriately. Intimate care plans placed consent at the forefront of the plans and provided clear guidance for staff on how to support each resident where required. Finances were protected through residents having financial assessments to ascertain the level of support they required and appropriate procedures were put in place in line with the assessment. Residents' possessions were safeguarded through regular updates of a list of residents' personal property and personal effects.

The inspector found that there were good systems in place to identify, assess and manage risks at both individual, centre and provider level. Adverse events were appropriately documented and there was evidence of learning from these incidents. The risk register was regularly reviewed and included risk assessments relating to COVID-19. These reflected changes in public health guidance for example, risk assessments related to dining out. The provider had a number of forums where risk was discussed and reviewed. In addition to regular review of assessments, there was evidence of multidisciplinary input into some risk assessments for example for a resident at risk of falls. The provider had a 'safety pause' each day whereby practices relating to health and safety and other aspects of care were communicated

to staff.

The provider had good measures in place to provide governance and leadership during the COVID -19 pandemic. There was an infection prevention and control policy in place. Staff had all completed additional training in relation to infection prevention and control. There were adequate hand hygiene facilities throughout the centre. On arrival to the centre, the inspector noted good practices in place for visitors such as a temperature check ,a visitors book and a COVID-19 questionnaire. There were adequate systems in place for waste and laundry management. The provider had an in-house COVID-19 screening team available in addition to access to a Clinical Nurse Specialist in infection prevention and control. The provider had completed the Health Information and Quality Authority's Self-assessment for COVID-19 for this centre and this was updated regularly. Weekly health and safety walkabouts took place and regular flushing and checks of water safety took place. The premises was noted to be very clean throughout and there were clear cleaning schedules in place.

Fire safety management systems were in place and had improved since the last inspection. The provider had containment and detection systems, emergency lighting and fire fighting equipment in place. One resident had a vibrating pillow to alert them in the event of a fire. However, this was not working on the day of the inspection and the person in charge informed the inspector that this was due to be repaired in the days following the inspection. The inspector viewed documentation to indicate that all other equipment was regularly serviced and checked. Fire drills were documented and there was evidence of learning from these drills. Drills recorded reasonable egress times.

The provider had identified significant maintenance issues in the annual review in 2021 which had been mostly actioned by the day of inspection. The premises was very homely and warm throughout. The centre had been recently painted. All of the residents showed the inspector their bedrooms. Residents in this house were elderly and the inspector noted the stairs in both houses to be very narrow and steep. While the residents could manage this on the day of the inspection, it was notably an effort for some. Additionally, due to the stairs being narrow, the person in charge told the inspector that they had been unable to source an evacuation chair to support residents in the event of a fire. Some of the bedrooms in the houses were noted to be very small, with residents being unable to move freely around their bed or to access their wardrobe comfortably. One resident complained that their room was too small and that they did not have ample space for their things. This had been logged as a complaint and the resident had additional shelving put in although they remained unhappy with their bedroom. Downstairs in the kitchen, files were stored in a locked press in addition to the medication. This was regularly used as an office space. To the rear of the property there was a beautiful large garden which the residents enjoyed during the summertime. While this premises was found to be meeting the needs of the residents on the day of inspection, there was a need for this to be kept under regular review to ensure it remained accessible to residents in line with their evolving physical needs.

Regulation 17: Premises

The premises consists of two houses adjoined and accessible through an internal door in the building. The provider had identified significant maintenance issues in the annual review in 2021 which had been mostly actioned by the day of inspection. The carpet required replacement and this was ordered. The premises was very homely throughout, with pictures of the residents engaging in activities and at events together. Much of their craft work was hung up on the walls and it had been recently painted. All of the residents showed the inspector their bedrooms. Residents in this house were elderly and the inspector noted the stairs in both houses to be very narrow and steep. While the residents could manage this on the day of the inspection, it was a notable effort for some. Some of the bedrooms in the houses were noted to be very small, with residents being unable to move freely around their bed or to access their wardrobe. One resident complained that their room was too small and that they did not have ample space for their personal belongings. This had been logged as a complaint and the resident had additional shelving put in although they remained unhappy with it. Downstairs in the kitchen, files were stored in a locked press in addition to the medication. This was regularly used as an office space. To the rear of the property there was a beautiful large garden which the residents enjoyed during the summertime. While this premises was meeting the needs of the residents on the day of inspection, there was a need for this to be kept under regular review to ensure it remained accessible and appropriate for residents in line with their evolving physical needs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had good risk management systems in place. The inspector viewed the risk policy, the risk register and incident and accident logs. These indicated that risk was appropriately identified, assessed, managed and kept under review at both centre and provider level. There was evidence of learning from adverse events.

Judgment: Compliant

Regulation 27: Protection against infection

The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. The inspector found the premises to be very clean

throughout with adequate facilities for hand hygiene. Waste and laundry were segregated and managed appropriately.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety management systems were in place and had improved since the last inspection. The provider had containment and detection systems, emergency lighting and fire fighting equipment in place. The inspector viewed documentation to indicate that this equipment was regularly serviced and checked. Fire drills were documented and there was evidence of learning from these drills. Drills recorded reasonable egress times. All residents had a personal emergency evacuation plan in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had an annual assessment of need carried out and there were corresponding care plans in place for each identified need. Residents also had a person centred retirement plan which was reviewed with them on a monthly basis. There was a clear schedule for each resident to have one to one time with staff each week where they could choose what to do. This generally entailed a trip out for coffee, shopping or a drive. Plans were regularly reviewed and amended where required and there was evidence of multidisciplinary input into plans where appropriate.

Judgment: Compliant

Regulation 6: Health care

All residents had access to a GP and a range of other health and social care professionals such as psychiatry, dentistry, occupational therapy, dietetics and a range of clinical nurse specialists within the service in dementia, infection prevention and control and behaviour. Residents had been supported to complete end-of-life care plans.

Judgment: Compliant

Regulation 8: Protection

The provider had good systems in place to ensure residents were protected from all forms of abuse. They had a policy which outlined staff responsibilities in relation to safeguarding and this was in line with national policy. Any safeguarding incidents were found to be documented, reported and investigated appropriately. Intimate care plans placed consent at the forefront of the plans and provided clear guidance for staff on how to support each resident where required. Finances were protected through residents having financial assessments to ascertain the level of support they required and appropriate procedures were put in place in line with the assessment. Residents' possessions were safeguarded through regular updates of a list of residents' personal property and personal effects.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Coolmine Court - Community Residential Service OSV-0003074

Inspection ID: MON-0026814

Date of inspection: 28/10/2021

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**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Centre had a stable staff team. The provider is recruiting for 1 staff nurse vacancy. • The regular staff in the house covers relief shifts normally. • In the event of no regular staff to cover the provider will make every effort to provide regular relief/ agency staff to the centre. • The provider has sanctioned 19.5 hours supermunery for the PIC each week.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Provider has a schedule for unannounced visits for the centre and visits will be to the centre in line with regulation. • The Provider will ensure that an annual review is carried out every year. • The Provider has sanctioned 19.5 hours supernumery hours for the PIC. • The Provider will make every effort to ensure regular staff cover any relief shifts in the centre.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The MDT will regularly review the residents in the designated centre. Should their assessed needs change then an appropriate action plan will be put in place in consultation with the resident.
• If required a second stair lift could be installed in the designated centre.
• The PIC will continue to link with the resident who is not happy with her bedroom and offer her the choice of moving to another designated centre with a larger bedroom if one should become available.

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(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	31/12/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2021
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	Red	31/12/2021
Regulation 23(1)(d)	The registered provider shall ensure that there	Substantially Compliant	Yellow	31/03/2022

	is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/12/2021