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:	North County Cork 1
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	14 February 2023
Centre ID:	OSV-0003306
Fieldwork ID:	MON-0035331

About the designated centre

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

North County Cork 1 is located in a large rural town and can provide a full-time residential service for a maximum of 10 residents (at the time of this inspection the provider was in the process of reducing the capacity of the centre to eight). The centre can accommodate both male and female residents from the age of 18 upwards with intellectual disabilities. The designated centre consists of a single-storey wing which is linked to a two-storey Georgian house (only the ground floor of the Georgian House is part of the designated centre). Seven resident bedrooms are located in the single-storey wing. The centre also has a dining room, a kitchen, a sitting room, a living room and bathroom facilities. The staff team consists of the person in charge, nurses, care assistants, activation staff and a domestic staff.

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 (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 14 February 2023	09:25hrs to 18:30hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

The designated centre was generally presented in a homely manner but given the age of the building, it was showing some signs and wear and tear. The atmosphere encountered by the inspection was generally calm on the day of inspection. Staff members on duty were seen to interact appropriately and positively with residents.

At the time of this inspection seven residents were living in this centre on a full-time basis while an eighth resident was in the process of transitioning into the centre on a phased basis. Seven of these eight residents were present in the centre on the day, all of whom were met by the inspector. While some residents did not communicate verbally and most did not engage directly with the inspector, the inspector did have an opportunity to observe residents in their home and in their interactions with staff members on duty.

On arrival at the centre it was seen that the centre was located within an enclosed grounds with some green areas and benches to the front of the centre. Upon entering the centre the inspector observed that the front door and doorframe appeared weathered and worn. At this time residents were noted to be sitting in communal areas, having breakfast or being supported with personal care. The inspector was introduced to residents by staff with some of these residents greeting the inspector. One of these resident talked about some family members and was later seen to move throughout the centre with staff and the person in charge engaging pleasantly with the resident as they did so.

The inspector spoke with another resident as they were in the centre's dining room. This resident indicated to the inspector that they liked living in the centre. When asked by the inspector what they liked about living in the centre the resident responded by saying "dunno". The inspector then asked was there anything they did not like about living the centre with resident answering "no" to this question. It was also indicated by the resident that they liked their bedroom with the resident saying that they shared this bedroom with another resident who they liked.

The other resident whom this resident was sharing a bedroom with was not met by the inspector during this inspection. However, documentation reviewed relating to this resident indicated they were happy to share a bedroom with their peer. The inspector later viewed the bedroom that was being shared by these residents. It was noted that it was one of the bigger bedrooms in the centre, had a privacy screen between the residents' beds and had space for the residents' personal possessions and toiletries to be stored separately. The inspector was informed that the residents had been offered the choice to move to another bedroom in the centre but declined the offer.

The inspector saw four resident bedrooms in total during this inspection and it was noted that they were all equipped with facilities to store personal belonging such as wardrobes, all had long radiators that ran the length of the bedrooms and that all

bedrooms were personalised. For example, one resident's bedroom had a large trophy which the resident had previously won for equestrian. Large parts of these bedrooms were brightly decorated and furnished but this stood in marked contrast to the flooring in the bedrooms which appeared older and more worn in appearance. The person in charge informed the inspector that this flooring required a buffering.

The seven resident bedrooms in this centre were located along the single storey wing of the centre while communal areas of the centre were located at the opposite end of the premises. These communal areas were seen to be nicely furnished, decorated and homelike in appearance. However, the premises which made up this centre was described as an old building and it was showing some signs of wear and tear. For example, some of the kitchen worktop appeared worn and the dining room floor was marked. The inspector was also informed that some doors were to be replaced and some work was ongoing to ensure that some fire doors in the centre operated fully as intended.

It was also noted that the premises which made up this centre was part of a building that comprised two floors but only the ground floor was registered as being part of this designated centre. This was reflected in the centre's statement of purpose and the floor plans that the centre was registered against. The first floor could be accessed from the ground floor via a stairs in the entrance hall with some bathrooms located on this first floor for staff use. At the bottom of the stairs was a stair gate that was seen in use throughout the inspection. No resident was observed by the inspector to attempt to open this gate to access the first floor.

As the inspection progressed into the afternoon it was noted that the atmosphere was generally calm and relaxed with staff overheard to interact pleasantly and respectfully with residents throughout. Some staff did indicate though one resident could be vocal sometimes and that another resident would prefer things to be quieter. It was also observed during this inspection that some residents in particular appeared to spend much of the initial hours of the inspection sitting on couches watching television. Records later reviewed indicated that watching television and listening to music were amongst the most commonly recorded activities that resident participated in while in this centre.

However, other records reviewed indicated that the residents were supported to engage in more meaningful internal and external activities regularly which was aided by the support of dedicated activation staff that were assigned to this centre Monday to Friday. Examples of activities which the residents did included gardening, arts, shopping, going for coffee, visiting local pubs and attending mass. In the afternoon of the inspection it was noted that all seven residents left the centre with the support of staff in a vehicle provided to go for lunch in a nearby hotel and were gone for a couple of hours. Most of these residents returned to the centre by the end of inspection.

Once these residents were back in the centre, some residents were seen relaxing in communal areas or their bedrooms. Staff members on duty were again noted to support resident in a caring and respectful manner, For example, as one staff member was supporting a resident to mobilise around the centre they were

overheard to ask the resident what room in the centre they wanted to go to. At the end of the inspection, one of the seven residents present on the day had not returned to the centre as they supported to visit a family member but was due to return later that night. The most recent annual review for the centre contained feedback from residents' families which indicated that all families were satisfied with staff, communication and residents' care the centre.

In summary, residents were observed and overheard to be supported appropriately by the staff members present. While some maintenance was needed in some areas, the premises provided was generally seen to be homelike. A generally calm and relaxed atmosphere was present in the centre with all residents supported to leave the centre during the day to go for a meal out.

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

Capacity and capability

It was indicated that there were no staffing vacancies in this centre and a consistency of staffing was provided to support residents. Some staff performance appraisals in 2022 had not been completed while the most recent annual review completed did not assess the centre against relevant standards.

This centre is run by COPE Foundation. Due to concerns in relation to Regulation 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and Staff development, Regulation 5 Individualised assessments and personal plan and Regulation 9 Residents' rights, the Chief Inspector is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in October 2022 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan the provider has provided an action plan to the Chief Inspector highlighting the steps the provider will take to improve compliance in the providers registered centres. These regulations were reviewed on this inspection and this inspection report will outline the findings found on inspection.

The current designated centre was last inspected by the Health Information and Quality Authority (HIQA) in July 2021 where an overall good level of compliance was found. Following that inspection the centre had its registration renewed until December 2024 for a maximum capacity of 10 residents. However, in early 2023 the provider applied to vary its registration conditions to reduce the capacity of the centre to eight residents. In doing so two of the three of the shared bedrooms that were once in this centre were to be change to single bedrooms. Taking into account additional information provided, the relevant applications were in the process of

being granted by the Chief Inspector at the time of this inspection. During the introduction meeting for this inspection the person in charge highlighted the benefits brought about by some residents no longer having to share a bedroom which included less sleep disruption.

The person in charge was responsible for this designated centre only and throughout this inspection demonstrated a good knowledge of the needs of the residents and the operations of the centre while also overseeing the staff team in place to support residents. In line with the regulations staffing must be accordance with the needs of residents and the centre's statement of purpose. The inspector was informed that there was no staffing vacancies in the centre and that no additional staffing resources were required to support residents. However, based on discussions with management of this centre and documentation reviewed, there was some uncertainty as to what the whole-time equivalent (WTE) staffing level for the centre actually was. Towards the end of the inspection it was indicated that WTE figure of 14.25 as outlined in the centre's most recent statement of purpose was correct with this figure comprising the person in charge, staff nurses, care assistants, activation staff and a domestic staff.

The staff working in this centre had access to copies of the Health Act 2007, relevant regulations and national standards set by HIQA. To ensure that staff had the necessary skills and knowledge to support residents, trainings in areas such as fire safety and safeguarding were provided. The majority of staff training was in date although it was noted that some staff were overdue refresher training in de-escalation and intervention. It was indicated by the person in charge that the provision of this particular training was being reviewed to see if it was still suitable for the residents in this centre. In keeping with the requirements of the regulations staff rosters were being maintained in the centre which indicated that there was a consistency of staff support. Specific documents relating to staff such as evidence of Garda Síochána (police) vetting are also required to be kept but these were held centrally by the provider and so were not reviewed during this inspection. Some volunteers were also involved with this centre and the inspector was informed that relevant documentation relating to these volunteers, such as Garda vetting, was also held centrally by the provider.

In accordance with the provider's policies, staff working in this centre were to undergo an annual appraisal as part of performance development. The most recent provider unannounced visit conducted for the centre in November 2022 indicated that such appraisals were underway. However, documents reviewed on this HIQA inspection indicated that while some performance appraisals had been carried out in 2022, others had started but not been completed. Such provider unannounced visits are required by the regulations and are important in monitoring the quality and safety of care and support provided. It was seen that the November 2022 provider unannounced visit was reflected in a written report with an action plan to address any issues identified. An annual review for the centre, another regulatory requirement, had last been completed for the centre in February 2022 and while this contained relevant information, it did not assess the centre against relevant national standards as required. A schedule of local audits was in place for the centre with audits conducted throughout 2022 and 2023 in various areas such as medicines and

finances. This provided assurance that monitoring systems were in operation to assess the centre on a systematic and ongoing basis.

Regulation 15: Staffing

It was indicated that there were no staffing vacancies in this centre and that staffing was in line with the centre's statement of purpose. Planned and actual staff rosters were being maintained which indicated a continuity of staff. Staff files were not reviewed during this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

At the time of this inspection some staff were indicated as being overdue refresher training in de-escalation and intervention although it was indicated that the provider was reviewing the provision of this training.

Judgment: Substantially compliant

Regulation 23: Governance and management

Some staff performance appraisals for 2022 had not been completed. The most recent annual review completed did not assess the centre against relevant standards.

Judgment: Substantially compliant

Quality and safety

While arrangements were in place to meet the needs of residents at the time of this inspection, some improvement was needed around aspects of personal planning and residents' rights.

A recent quarterly notification submitted to the Chief Inspector, indicated that all residents in this centre had restricted access to their own money. This was queried during this inspection and it was indicated that the money of two residents was

managed by their families and that money for these residents had to be requested from their family members. It was stressed by the person in charge though that any money requests for these two residents were met. For the other six residents it was initially indicated on inspection that they had bank accounts in their own name but following the inspection it was clarified that these residents' funds were in one nominal account that was held by COPE Foundation. Under this arrangement in order for residents to gain access to their money, a requisition form had to be completed by the person in charge which was then submitted to the provider for review. Once this requisition form was approved it would then be necessary for residents and/or staff drive to drive from this centre to the provider's central offices (a journey of approximately 50 kilometres) to collect the money.

The inspector did query how long this process could take to complete and received varying responses of between one day and one week. While it was noted that such practices were long-established, such arrangements and the steps involved, did not provide assurance that residents had sufficient control over and ease of access to their own money. The inspector was informed that the provider was in the process of reviewing such arrangements and were trialling an alternative arrangement for one resident who was living in another designated centre. Aside from residents' finances it was seen that arrangements were in place to ensure that residents were able to retain control over their personal possessions in this designated centre. These included having suitable facilities available for residents to store their personal possessions while it was also noted when reviewing documentation relating to residents that they had recently reviewed possessions lists in place. Such possessions lists were found to be detailed in providing descriptions of the possessions that residents owned. When reviewing such documentation, the inspector also came across consent booklets for some residents.

These booklets contained information on what consent was and at the rear of the booklet was a consent card which was intended to indicate consent to treatment for various health and social professionals. In the consent cards seen it was seen that they all indicated that residents had consented to such treatment but it was noted that these consent cards were unsigned and undated so it was unclear when they had last been reviewed. The inspector was informed that these consent booklets were being reviewed. It was also indicated that the arrangements for resident forums in the centre had been recently changed. Such forums can be used as a means to give residents information and to consult with them. A sample of notes of completed resident forums from recent months were reviewed and these indicated that topics such as activities, choices and complaints were to be discussed with residents. However, the notes of these forums did not indicate if all such areas were discussed with all residents while the forum agenda did not provide details of how residents engaged in decision in relation to their home or information sharing. This had been highlighted by the provider's unannounced visit to the centre in November 2022.

In response to such matters the person in charge outlined how in January 2023 the process around resident forums had been changed to make them more meaningful to residents. This involved changing the forum agenda, using a white board in the centre's dining area to reflect any resident requests and the use of a picture book as

a means to aid communication with residents who did not verbally communicate. It was also indicated that the frequency of resident forums had increased from monthly to weekly although the most recent forum notes available for the inspector to review were from 23 January 2023. The white board referenced by the person in charge was seen though on display in the dining area which did list some resident requests. Other notice boards and signs were on display in this room and amongst these the inspector did observe that information relating to particular diets of residents was present on a wall. As this room was a communal area, the presence of this information in a clearly visible location impacted residents' privacy.

Information relating to making a complaint and accessing independent advocacy services were also on display in the dining area. To provide additional support, each resident had been assigned specific key workers from the staff team. When speaking with one of the staff, who was a key worker for a resident, they outlined how their role was to advocate on behalf of the resident and to support them with their goals. Goals for residents were identified for residents through a person-centred planning process which was to involve residents and their families. The inspector reviewed a sample of person-centred planning documents and saw that goals were identified for residents such as holidays, attending sporting events and increasing community participation. Time frames and responsibilities for assisting residents with these goals were identified for some goals but not all. Documentation reviewed indicated that some of the residents' goals had been achieved but for other goals it was not indicated how or if they had been progressed.

This was queried with the person in charge and there was other evidence available that some of these goals had actually been progressed. For example, one resident's bedroom had been done up which was seen by the inspector. However, not all of the identified goals had been progressed most notably for one resident who had goals identified in January 2022 to have a weekend away and to get a basketball hoop. The inspector was informed that the resident had not had a weekend away and did not have a basketball hoop at the time of inspection with the former having been carried forward as a goal in the person-centred planning process completed for the resident in February 2023. Documents relating to resident goals was contained with their individual person plans. Such plans are important to provide guidance on supporting the health, personal and social needs of residents and on this inspection it was seen that all eights residents living in this centre had a personal plan in place, a sample of which were reviewed by the inspector.

Under Regulation 5 Individualised assessments and personal plan, there are specific requirements that must be adhered to in preparing, reviewing and presenting personal plans. From the sample reviewed it was seen that some of the requirements had been met. These included the personal plans being subject to an annual multidisciplinary review while the contents of personal plans, in general, where found to have been reviewed within the previous 12 months. Personal plans should be also informed by a comprehensive assessment of all health, personal and social needs to be conducted on an annual basis at least and when reviewing the sample of person plans the inspector did see recent assessments of health needs. He was informed that there was no equivalent assessment document for personal or social needs but it was highlighted that information relating to these areas would be

captured by the person-centred planning process. However, the regulations do require personal plans to be presented in an easy-to-read format but the inspector was informed that these were not in place.

Aside from matters related to personal plans, Regulation 5 also requires that there are suitable arrangements in place to meet the health, personal and social needs of residents. There was evidence which indicated that such arrangements were provided for at the time of this inspection. For example, the reduction in shared bedrooms had been highlighted as a benefit for some residents while the presence of dedicated activation staff for the centre did provide more opportunities for activities which supported the residents' social needs. In addition, arrangements were in place to support the assessed health needs of residents and on the inspection it was seen that some residents were visited by certain health and social professionals including a chiropodist and an occupational therapist. It was highlighted to the inspector though that the needs of residents had increased in recent years. Given the profile of residents living in this centre it was probable that their needs would increase further in the future so there would need be ongoing assessment and monitoring of these residents' needs.

Regulation 5: Individual assessment and personal plan

Personal plans were not available in an easy-to-read format. Some identified goals for residents lacked evidence of how they had been progressed or had not been progressed. Some goals identified for residents did not assign time frames or responsibilities.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The arrangements in place for residents' finances in this centre did not fully enable residents to have control over their own finances. Consent cards were in place for residents but these were unsigned and undated so it was unclear when they had last been reviewed. Information on display in a communal area relating to required diets of residents had the potential to impact residents' right to privacy.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for North County Cork 1 OSV-0003306

Inspection ID: MON-0035331

Date of inspection: 14/02/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: At the time of this inspection some staff were indicated as being overdue refresher training in de-escalation and intervention although it was indicated that the provider was reviewing the provision of this training. • The training matrix was reviewed and updated since inspection date with the following competed training and intendified training to be completed by 30.6.23. • All outstanding Positive Behaviour Support training completed on 15.2.23 • Fire training outstanding one staff. Completed on 26.2.23 • Manual Handling outstanding by one staff. Booked and to be completed by 13.3.23. • The use of Saftey Intervention Programme risk assessed by PIC and PPIM. Planned one day verbal intervention programme to be completed by all stafff by 30.6.23 .	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • An annual review is arranged for 11.4.23 . The Chief Operations Officer will highlight with internal auditors to address assesing the centre against relevant national standards as required in regulations . To be completed by 11.4.23. • Performance appraisals for 2023 commenced on 21.2.23. All performance appraisals to be completed by PIC by 30.3.23.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Easy read care plans to be completed for all residents by 30.4.23.	

• The PIC completed an audit on 27.2.23 of all person centre plans. Action plan from audit devised on areas for improvement. To be completed by 30.4.23. • Guidelines for keyworkers was identified as policy for the month in February 2023, to inform staff of their roles as keyworkers. Completed 28/2/23. • PCP guidelines have been shared with all staff to read prior to commencing new PCP's for 2023. PCP's to be completed as a collaborative approach between resident, next of kin, activation staff and keyworker and coordinated by PIC. Keyworkers will be named in PCP to complete set goals, using the effective goal setting standard SMART: Specific, measurable, achievable, relevant and time-bound.

Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Individual consent booklets were reviewed with all residents signed and dated. Completed on 21.3.23 • On date of inspection 14.2.23 dietary requirements for residents removed from the notice board in the dining room. • All staff informed that this board was impacting on residents right to privacy. Completed 15/2/23. • The PIC will develop a local protocol for the designated centre to request funds from resident centrally. The protocol will refer to ensuring requests for residents' funds in a timely manner to ensure resident is not without sufficient funds for a period of time. To be completed by 31.3.23. • The organisation is currently reviewing the process of the PPE account which is held centrally for some residents. This will be reviewed under "Money Management Policy Guidelines". The outcome will be residents will be given cards to access their own funds. This will give residents control over their own finances. To be completed by 15.1.24	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2023
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	11/04/2023
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance	Substantially Compliant	Yellow	27/03/2023

	manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/04/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/04/2023
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	30/04/2023
Regulation	The registered	Substantially	Yellow	21/03/2023

09(2)(a)	provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Compliant		
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	15/01/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	14/02/2023