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:	Arranmore
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 8
Type of inspection:	Unannounced
Date of inspection:	16 January 2025
Centre ID:	OSV-0003591
Fieldwork ID:	MON-0044391

About the designated centre

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

Arranmore is a designated centre operated by St. John of God Community services and is situated on a campus based setting in South Dublin. It is a large one storey property that provides residential services for a maximum of nine residents. There is one dining area, kitchen, nine bedrooms, a staff office, a medication room and a TV lounge. There are two accessible bathrooms. There is a small grassy and paved area to the back of the building where residents, staff and family members can sit. There is also access to a swimming pool, day services, an oratory, gymnasium and multi-sensory room located on the campus. Residents are supported 24/7 by nursing staff, healthcare assistants and social care workers. Residents have access to multidisciplinary supports in the organisation such as; social workers, physiotherapists, occupational therapists, speech and language and psychology, as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Thursday 16 January 2025	12:00hrs to 18:30hrs	Jennifer Deasy	Lead
Thursday 16 January 2025	12:00hrs to 18:30hrs	Karen McLaughlin	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the ongoing regulatory monitoring of the centre. The inspection focused on how residents were being safeguarded in the centre.

Two inspectors attended the centre and had the opportunity to meet residents, some family members and staff. Inspectors used observations of care and support, conversations with key stakeholders and a review of documentation to inform judgments on the quality and safety of care. The inspectors found that, overall, residents were in receipt of good quality care which was delivered by a familiar staff team in a kind and respectful manner. There were some improvements required to the oversight of residents' finances to ensure that these were safeguarded in the most effective way possible.

The designated centre is comprised of one large building located on the provider's campus in Dublin City Centre. The centre is home to nine residents, all of whom have high support needs and require nursing inputs in respect of their assessed needs. The provider had reduced the number of registered beds in the centre within the previous registration cycle and this was found to be having a positive impact on the quality of care. The atmosphere of the centre was noted to be calm and relaxed. Staff communicated with residents in a gentle manner and clearly knew residents' individual preferences in respect of their care and support.

There had been a number of changes to the governance and management team of the centre in recent months. These changes had resulted in some gaps in the oversight of the quality of care, and in particular in respect of the oversight of staff training. This will be discussed in further detail in the Capacity and Capability section of the report. The inspectors met the new person in charge, clinical nurse manager 1 and the programme manager over the course of the inspection. The inspectors were told that the management team had identified areas for improvement through their audits and had plans in place to address these.

The provider had also completed works to the premises in recent months in order to enhance the facilities. For example, a new sensory room had been installed and a family room provided a separate visiting space for family members. Staff members told the inspectors that residents really enjoyed the sensory room with many residents choosing to use it on a daily basis.

Each resident had their own bedroom which was equipped with aids and appliances required to support their assessed needs. Residents' bedrooms were personalised and displayed their favourite photographs and art work. The management team told the inspectors of their plans to further enhance and personalise residents' bedrooms.

Residents also had access to accessible wet rooms which were seen to be clean and

well-maintained. A large sitting room was equipped with a karaoke machine and a Magic Table (an interactive sensory toy), both of which were used by the residents on the day of inspection. Staff members supported residents to engage in karaoke, singing along with them and encouraging residents' participation.

Many of the residents in the centre communicated through non-verbal means. Some residents engaged with the inspectors through eye contact or body language. Two residents spoke to the inspectors. One to say hello and the other to tell them a bit about their life in the centre. This resident showed the inspector their art work and told them about their recent outing for lunch and a walk.

The resident told the inspectors that their day service was closed as the heating was broken, and that this was why all the residents were in the centre on the day of inspection. The management team informed the inspectors that day service staff had been redeployed to the centre and this was effective in ensuring that residents continued to be supported to have active days while waiting for the heating in day service to be fixed.

Two residents had medical appointments on the day of inspection and the inspectors saw that there were sufficient staff, including a bus driver, and vehicles to support their attendance at these appointments. Inspectors observed two mealtimes in the centre. A chef formed part of the staff team for the centre and prepared meals for the residents. The inspectors saw that meals looked appetising and were modified in line with residents' feeding, eating, drinking and swallowing care plans. There were sufficient staff available to assist residents with their meals and inspectors saw that staff took care and time to feed residents in a dignified manner. Staff also ensured that those residents who required adaptive equipment for meals had this available to them.

Inspectors heard and saw kind, respectful and gentle interactions between residents and staff. Staff were heard consulting with residents about their care and asking for consent before starting any direct care. Inspectors spoke to one agency staff and one day centre staff regarding residents' communication needs. These staff told the inspectors that they had received a comprehensive induction from management regarding residents' needs and how best to support them.

Inspectors also met a family member of a resident who had been recently moved into the designated centre. This family member told inspectors that they were very happy with the quality of care that the resident was receiving. They felt that the resident was safe and was well looked after. They complimented the staff and management team on their standard of communication with family members.

Overall, this inspection found that residents were living in a homely environment and were in receipt of good quality care. However, recent changes to the oversight arrangements had resulted in some gaps in the oversight of staff training, and in particular in compliance with refresher safeguarding training. Additionally, improvements were required to the oversight of residents' finances to ensure that these were safeguarded as effectively as possible. These areas for improvement had been identified by the new management team through their audits and there were

plans in place to begin to address these deficits.

The next two sections of the report will describe the governance and management arrangements in the centre and how these were effective in ensuring there were appropriate safeguarding practices in the centre, as well as a description of the quality and safety of care of residents, with a particular focus on safeguarding.

Capacity and capability

This section of the report describes the governance and management arrangements and how these ensured oversight of safeguarding practices in the centre. Overall, inspectors found that there were improvements required to the performance management and development of staff; however, this had been identified by management team and there were action plans in place to address some of the areas of deficit at the time of inspection.

There had been a number of changes changes to the management team of the designated centre within the past 12 months, with a new clinical nurse manager 1, person in charge and programme manager being appointed to oversee the centre. The inspector saw that there were gaps in the oversight of the quality and safety of care prior to the new local management team commencing employment. For example, records of monthly staff meetings and records of safeguarding referrals from 2024 were inconsistently maintained in the centre. Additionally, there were gaps in staff compliance with mandatory training in adult safeguarding. The new management team had, however, completed a series of audits since commencing in their posts and had implemented action plans to address some of these risks. The provider level audits were also comprehensive and identified some of the areas which required improvement including, for example, in the management of residents' finances.

There were a number of gaps in the staffing complement at the time of inspection; however, inspectors saw that the provider had ensured that regular and consistent relief and agency staff were used to fill gaps in the roster.

The inspectors spoke with a number of staff over the course of the day and found that staff had received a comprehensive induction and were well-informed regarding the residents' individual needs and preferences in respect of their care.

Regulation 15: Staffing

The staffing arrangements in the centre, including staffing levels, skill mix and qualifications, were effective in meeting residents' assessed needs.

Inspectors observed staff engaging with residents in a respectful and warm manner, and it was clear that they had a good rapport and understanding of the residents' needs.

There was a planned and actual roster maintained by the person in charge. Inspectors reviewed actual and planned rosters at the centre for November and December 2024 and the current January 2025 roster. The centre was operating with three whole time equivalent vacancies at the time of inspection. A recruitment campaign was ongoing. In the interim regular agency staff were being used which was supporting continuity of care.

The inspectors spoke to a number of staff over the course of the day including agency staff and recently recruited staff. These staff told inspectors that they had received a comprehensive induction to the centre and were supported to complete shadowing shifts before being put on the roster. Staff told the inspector that they had completed training in safeguarding and had received education on residents' needs including their communication needs.

Agency staff received a full induction as described above. Furthermore a guidance document for all agency/relief staff included a photo and names of each resident, their daily routine and the location of their personal plans alongside fire safety information, cleaning schedules, policies and procedures and guidance on how to manage and report on residents welfare and protection concerns.

These processes were ensuring that, even with whole time equivalent vacancies, the residents were in receipt of care from suitably skilled staff who were familiar with residents' individual assessed needs and preferences.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors were told that it was the provider's policy to hold monthly staff meetings. While inspectors were told that staff meetings were held regularly in 2024, there were an absence of records to evidence that these meetings had taken place and to detail topics which were discussed. The new management team had identified this in their audits since commencing in post and, since November 2024, records of monthly staff meetings had been maintained.

Additionally, inspectors were told that staff had not received supervision over the last 12 months as per the providers policy; however, a schedule was in place to ensure all staff received supervision for 2025.

A training matrix was reviewed by the inspectors. The inspectors saw that 4 staff had not completed mandatory training refreshers in Safeguarding of Vulnerable Adults and 5 staff had not completed Children First refresher training.

The staff training audit, reviewed by inspectors, required updating as it did not accurately reflect or capture training needs for staff working in the centre. For example, staff spoken with were unsure if they had completed human rights training. However when inspectors reviewed the training matrix, it was evident that 5 staff had completed modules on human rights.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, there were good governance and management arrangements and systems in place but some improvements were required.

The inspectors saw that gaps in the local management structures within the past 12 months had impacted on the oversight of key aspects of safeguarding in the centre. For example, 4 staff required safeguarding refresher training. Staff meeting records were also not maintained and so it was not evidenced that safeguarding was a topic which was discussed with the staff team.

Safeguarding referrals and the response from the safeguarding and protection team were not maintained in the designated centre and it took some time for these to be accessed on the day of inspection. Inspectors afforded two additional working days to the provider to submit information which was not available on the day. The required information was submitted within this timeframe. Additionally, inspectors saw that there had been a failure by the provider to follow up on recommendations from the safeguarding and protection team in respect of an allegation of financial abuse for one resident.

The provider's policies and procedures to guide staff in respect of managing residents' finances required review. The provider's policy on service user private property and finances had not been updated since March 2019. The policy did not reflect current legislation and there was an absence of local operating procedures to guide staff when issues arose with residents' finances. For example, if residents had insufficient funds available to them. This will be further discussed under Regulation 8.

The new management team, including the clinical nurse manager 1 and the person in charge, had completed a series of comprehensive audits since commencing in their role. These audits, in areas including risk management and safeguarding, had identified some of the above areas as requiring enhancement. The management team had implemented an action plan and inspectors saw that many of these actions were in progress at the time of inspection. This demonstrated that the new governance and management systems were effectively identifying gaps in compliance and in implementing action plans to address these.

The provider had completed required audits including an annual review and six monthly audits. These were reviewed by the inspectors and were seen to be

comprehensive and detailed. Action plans were implemented where required. These audits identified some of the risks also found by inspectors, for example, the six-monthly audit in October 2024 identified that improvements were required to the management of residents' finances to ensure that the practices in the centre were in line with current legislation.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived there. Regulations which relate to safeguarding were specifically assessed as part of this thematic inspection. In general, inspectors saw that residents were living in a clean and homely environment which was suitable to meet their assessed needs. Residents were seen to be supported to access relevant health care appointments and to live busy and active lives in line with their needs and preferences. However, improvements were required to the oversight of residents' finances and to the procedures in place to ensure that residents were fully consulted with and informed regarding their rights.

The provider had ensured that the designated centre was designed and laid out in a manner that met residents' assessed needs. Many of the residents in this centre had assessed mobility needs. The centre was large enough to accommodate mobility aids and was furnished with aids and appliances to assist residents in the provision of daily care. The provider has also completed work to the centre to enhance the available facilities and had provided a sensory room and a family visiting room for the residents to use.

Residents' files were reviewed by the inspectors and it was seen that residents had a comprehensive individual assessment which detailed their assessed needs and was used to inform person-centred care plans. Staff spoken with were informed of residents' assessed needs and had received a comprehensive induction. Staff were seen providing care and support, such as assistance at mealtimes, in line with residents' care plans. Residents' files also contained up-to-date intimate care plans and positive behaviour support plans for those residents who required them.

Improvements were required to the oversight of residents' finances. There were a number of areas for improvement noted including in respect of residents' contracts of care, local operating procedures and the oversight of financial safeguarding concerns. The provider had self-identified some of these issues and was in the process of implementing action plans to address these at the time of inspection. However, the inspectors found that the provider had failed to implement the recommendations of the safeguarding and protection team in respect of one allegation of financial abuse in a timely manner.

Improvements were also required in respect of the consultation with residents on

the running of the centre. Weekly residents' meetings were supposed to happen in line with the provider's policy; however, inspectors saw that an audit by the management team had identified that these had only occurred 33% of the time in 2024. Staff spoken with were unsure if they had completed human rights training. However, inspectors did see that staff practices in the centre were upholding residents' dignity and were supporting residents to have control over their lives. For example, inspectors saw staff asking residents' consent before providing care, taking care to protect residents' clothes during mealtimes and closely watching residents' non-verbal communication to determine their readiness for their food when direct assistance was provided.

Regulation 17: Premises

The registered provider had made provision for the matters as set out in Schedule 6 of the regulations.

The designated centre was seen to be clean, warm and well-maintained. It was designed and laid out in a manner suitable to meet the residents' assessed needs. Communal rooms and corridors were large enough to accommodate residents' required mobility aids. Residents had access to a sitting room with an interactive sensory table and a kitchen and dining room. The provider had recently completed works to the centre to enhance the facilities including adding a sensory room and a family room. Inspectors were told that residents particularly enjoyed the sensory room.

Each resident had their own bedroom with sufficient storage for their personal belongings. Residents' bedrooms were personalised with photographs and art work. The management team described to inspectors further improvements which they intended to make to further personalise residents' bedrooms. Bedrooms were equipped with technology and equipment in line with residents' needs. For example, some bedrooms has ceiling tracking hoists, hospital beds and mobility aids.

The centre had two large accessible wet rooms which were equipped to support residents' personal care needs in line with their assessed needs. These wet rooms were clean and maintained in a hygienic manner.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed the individual assessments and care plans for three residents. The inspectors saw that each resident had a comprehensive assessment of need and up-to-date care plans for each assessed need. The inspectors saw that residents had access to the required multi-disciplinary professionals in line with their

needs. Two of the residents were supported to attend multi-disciplinary appointments on the day of the inspection by the staff team.

Residents' care plans were reviewed. These were seen to describe to staff comprehensively how to meet residents' assessed needs. Staff were seen providing care in line with these plans. For example, staff were seen providing mealtime support to residents who required it in line with their care plans, ensuring that residents had access to feeding aids as needed.

Intimate care plans were available on file which detailed residents' personal care needs. These were written in person-centred language an detailed steps to support residents and measures to uphold their privacy and autonomy.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. Clear behaviour support plans were in place to guide staff on how best to support these residents, and regular multi-disciplinary input was sought in the review of residents' behavioural support interventions.

Inspectors completed a review of restrictive practices in place in the centre and found that all restrictive practices were logged, regularly reviewed and risk assessed in line with the provider's policy. In addition, the person in charge and staff team were monitoring the use of restrictive practices and attempting to reduce the frequency of use within the designated centre.

Judgment: Compliant

Regulation 8: Protection

A review was required to ensure that residents' finances were safeguarded. Inspectors found a number of areas which required improvement in respect of the management of residents' finances:

- Of the three residents' contracts of care that were reviewed by the inspectors, none of these were signed. Some of the contracts of care were blank and did not provide information on the fees to be paid or services provided
- A financial audit completed on 23/12/2024 identified that residents had not been consulted with regarding their finances and that none of the residents had access to ATM cards.

- An allegation of financial abuse in respect of one of the residents had been submitted to the Chief Inspector and to the Safeguarding and Protection Team in December 2023. The safeguarding and protection team had set out actions for the provider to complete in order to safeguard the resident's finances however there was no evidence that these actions had been completed on the day of inspection. The inspectors allowed two additional days for information to be submitted in respect of this allegation. The evidence submitted demonstrated that the provider had, subsequent to the inspection, taken measures to safeguard the resident's finances. The provider also submitted a further referral to the safeguarding and protection team and to the Chief Inspector in respect of their delay in investigating and taking steps to safeguard finances.
- Financial passports on residents' files did not reflect current legislation or court orders. For example, one financial passport detailed that a residents' family had the authority to hold the resident's disability allowance. However there was no decision-maker appointed in line with the assisted decision making and capacity act.
- Another resident's financial passport did not reflect a recent court order in respect of how their finances were to be managed. The information in the passport was inconsistent with the court order directions.
- The procedures around supporting residents to access their bank accounts also required review. The inspectors saw that the cash book for one resident, who had their own bank account, detailed that they had very minimal funds available to them to spend in the first two weeks of January 2025. The inspector was told that this was due to staff who were co-signatories on the account being on leave, and so cash could not be withdrawn. The inspector was informed that activities were paid for by a manager on behalf of the resident so there was no impact on the resident's access to daily activities. However, the procedures for supporting residents to access their finances and for staff to follow in the event of there being a problem with these procedures required review

Judgment: Not compliant

Regulation 9: Residents' rights

The new management team's audits had identified there were significant gaps in the frequency of residents' weekly meetings in the centre during the previous year. Improvements were seen since the new management team were employed, with residents' meetings occurring weekly since the 3rd of January. The minutes of the last two residents' meetings were reviewed by the inspectors and agenda items included updates on maintenance, menu planning, activity planning, updates on service provision (including updates on the re-opening of day service), complaints, safeguarding and advocacy.

Some of the residents did not have access to their own finances. This is discussed

further under Regulation 8: Protection.

Inspectors saw that staff interactions with residents were in a manner which upheld residents' dignity and provided residents with choice and control. Staff were seen offering residents choices, responding to their non-verbal communication and providing direct assistance in a manner which respected residents' right to dignity and privacy.

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	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Arranmore OSV-0003591

Inspection ID: MON-0044391

Date of inspection: 16/01/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Staff meetings will be held monthly, 2 completed in 2025. Schedule for 2025 in place and records are maintained. Time frame: Completed monthly • Frontline staff supervision will be held as twice per annum unless otherwise required as per the Human Resource Policy: Supervision. Schedule of supervision is displayed in the office. In addition, staff will have 1 PDR will be scheduled once a year for all staff. As of the 20.02.25, 17/21 PDRs have been completed and the remaining scheduled. Time frame: 07 March 2025. • Staff training will be scheduled as required. All outstanding training are scheduled. Time frame for completion of all scheduled training is the 30.04.2025	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Staff training on Safeguarding Vulnerable Adults from Abuse and Children's First has been completed by all staff. Staff training record is maintained. Time frame: Completed. • Safeguarding concerns will be reviewed in line with SJOG Standing Operating Procedure for Safeguarding of Vulnerable Adults at Risk of Abuse. A new safeguarding cover page will be maintained with all safeguarding concerns to ensure governance and oversight. • Finances: All finances will be reviewed and any concerns identified will be dealt with in line with appropriate policy. A finance audit has been completed with actions identified. All financial assessments and finance related support plans will be updated. If residents can independently use a bank card, they will be supported to have access. Time frame: 28 February 2025	

• Actions arising from the finance audits will be completed by 30.04.2025 • Audit schedule is in place and all actions identified will be recorded on the Quality Enhancement Plan and is currently in place.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• Staff training on Safeguarding Vulnerable Adults from Abuse and Children's First has been completed by all staff. Staff training record is maintained. Time frame: Completed.
• Safeguarding concerns will be reviewed in line with SJOG Standing Operating Procedure for Safeguarding of Vulnerable Adults at Risk of Abuse. A new safeguarding cover page will be maintained with all safeguarding concerns to ensure governance and oversight.
• Finances: All finances will be reviewed and any concerns identified will be dealt with in line with appropriate policy. A finance audit has been completed with actions identified. All financial assessments and finance related support plans will be updated. If residents can independently use a bank card, they will be supported to have access. Time frame: 28 February 2025
• Actions arising from the finance audits will be completed by 30.04.2025
• Audits schedule is in place and all actions identified will be recorded on the Quality Enhancement Plan and is currently in place.
• Safeguarding will be standing item for discussion at staff meeting and local designated centres meeting. Team meeting will take place monthly and commenced in Dec 2024, records are maintained. Time frame: Completed

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• Finances: All finances will be reviewed and any concerns identified will be dealt with in line with appropriate policy. A finance audit has been completed with actions identified. All financial assessments and finance related support plans will be updated. If residents can independently use a bank card, they will be supported to have access. Time frame: 28 February 2025
• Actions arising from the finance audits will be completed by 30.04.2025
• A Weekly residents meeting will be held every Friday and minutes will be maintained, this commenced on the 13th of Dec 2024. Governance and oversight regarding quality of meeting will be maintained by frontline managers. Time frame: Completed

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.	Not Compliant	Orange	30/04/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	07/03/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2025
Regulation	The registered	Substantially	Yellow	30/04/2025

23(3)(a)	provider shall ensure that effective arrangements are in place to support, develop and performance 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.	Compliant		
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2025
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	30/04/2025