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:	Camphill Community of Ireland Greenacres
Name of provider:	Camphill Communities of Ireland
Address of centre:	Dublin 14
Type of inspection:	Unannounced
Date of inspection:	14 September 2021
Centre ID:	OSV-0003623
Fieldwork ID:	MON-0033731

About the designated centre

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

Greenacres is a residential home for three adults with an intellectual disability who require low to medium supports. The centre is located in a suburb in South Co. Dublin and is close to a variety of public transport links. There are shopping centres, pubs and local shops within close proximity of the centre. Residents have the opportunity to attend day services or avail of training, employment or volunteer work in their local community. Residents are supported 24 hours a day, seven days a week by social care workers and volunteers. The property has seven bedrooms, a kitchen and dining room, and a sitting room. The property also has a large garden with a seating area and a storage shed, and a detached office at the back of the garden. Each resident has an ensuite bedroom.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Tuesday 14 September 2021	9:30 am to 5:05 pm	Marie Byrne	Lead

What residents told us and what inspectors observed

Overall the inspector of social services found that residents were being supported to enjoy a good quality of life. The provider had systems in place to monitor the quality and safety of care and support in the centre and had recently identified areas where improvements were required in relation to the implementation of the organisation's management systems and the oversight of documentation in the centre. It was evident that residents were consulted with in relation to the day-to-day running of the centre and were playing an active role in their home. They were being supported to make choices and to spend their time engaging in activities they enjoyed. Their independence was promoted and encouraged and their talents were encouraged and celebrated.

In line with public health guidance during the COVID-19 pandemic and in respecting residents' wishes to continue with their day as planned, the inspector did not spend extended periods with them. The inspector met and briefly engaged with the three residents living in the centre during the day. They used observations, discussions with residents, discussions with staff and a review of documentation to get a picture of what life was like for residents in the centre. Residents appeared comfortable and content in their home throughout the inspection and two residents told the inspector that they were happy and felt safe living in the centre.

On arrival the inspector was greeted by a resident, who checked their identification and then welcomed the inspector into their home. The gave the inspector a tour of parts of their home and talked about what it was like to live in the centre. They said they were happy most of the time, and were getting on better with their housemates lately. They described their plans to make improvements to their bedroom and shared sketches they had made of the design and layout they would like in their room. They described the type of built in storage, the style of bed and the colours they would like in their room. They had a passion and talent for working with technology and shared tips with the inspector on how to make the most of the storage and WiFi on their computer. They were also a big fan of a particular comic book and movie hero, and had a creative flair for designing and decorating items in their room with pictures and collages of their favourite character. They described how important it was for them to stay busy doing projects they enjoyed and talked about their passion for art and music. They played the piano, guitar and drums and the inspector observed a drum set in the outdoor office building and a piano in the living room.

During the inspection, the inspector observed residents taking part in the upkeep of their home. For example, residents were doing the dishes, clearing the table after meals, and hanging out their washing. After breakfast one resident went to day services for the day, and returned in time for their evening tea. They appeared happy heading off, and on their return. Another resident did some chores around their home after breakfast and then went out for a walk with a staff member followed by lunch out with their family member. On their return they had a chat with

the inspector and told them all about living in the centre. They said they were happy and that the food was lovely. They discussed how important it was to them to be independent and said they liked to help out in their home as much as possible. They talked about their health and wellbeing and described what they would do if they had any concerns about their health, their relationships with their housemates, or in relation to they home. They also talked about how important their relationship with their keyworker was and how lucky they were to be supported by such "good staff".

Staff who spoke with inspectors were knowledgeable in relation to residents' likes, dislikes, and support needs. They were motivated to ensure that each resident was living their best life, contributing to the running of their home, and part of their local community. Residents were observed to be comfortable in the presence of staff and the volunteer, and the inspector observed kind, caring and respectful interactions throughout the inspection.

The premises were designed and laid out to meet the number and needs of residents. There was sufficient private and communal spaces and storage available for residents' personal belongings. Residents' bedrooms were decorated in line with their preferences and there was art work and photos on display throughout the house.

Residents and their representatives' experience of the service were sought as part of the centre's annual and six monthly reviews. The feedback in these reviews was positive and residents indicated they were well supported, liked living in the centre, were aware of the complaints process. Residents representatives reported that communication was great with the centre and that staff were great. One residents' representative commented on how there had been a lot of staff changes. However, they also stated they didn't feel this had an impact on their relatives care and support. When asked about areas for improvement another residents' representative said they would like to see "more activities in the day centre".

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 the service's quality and safety.

Capacity and capability

Overall the inspector found that the governance and management arrangements in the centre were ensuring that residents were in receipt of a good quality, person-centred and safe service. However, improvements were required in relation to the implementation of systems to ensure the quality of care and support for residents was consistently monitored and that documentation was available to demonstrate this. Improvements were required in relation to staffing numbers, staff training, auditing in the centre, staff meetings, documentation relating to residents' finances, documentation relating to fire drills, and the oversight of risk.

The provider was found to be identifying most of these areas of improvement in their annual and six monthly reviews. For example, in their latest six monthly provider visit they had recognised that improvements were required in relation to staff numbers and training, the frequency of staff meetings, and the completion of audits in the centre. Some of the findings of the provider's reviews were repeated in a number of subsequent reviews with limited evidence of the implementation of some of the required actions. In addition, some actions marked as complete in these audits and reviews were not found to be completed on the day of the inspection. These areas for improvement were not found to be contributing to any significant risk for residents at the time of this inspection.

The inspector found that members of the staff team who they spoke with during the inspection were highly motivated to achieve positive outcomes for residents. Residents were supported by a staff team consisting of paid employees and one volunteer. A new person in charge and person participating in the management of the designated centre (PPIM) had commenced in the centre a number of weeks before the inspection. They were in the process of getting to know residents and were being supported by another PPIM who had also briefly worked as person in charge of this centre while the provider was recruiting to fill that position. They each described their plans to support residents in line with their wishes and preferences and how important it was to them to ensure that each resident was enjoying a good quality of life. Residents appeared comfortable in their presence and to take the time to speak with each of them during the inspection.

At the time of the inspection there was one staff vacancy and the provider was in the process of recruiting to fill this. While recruiting they were attempting to ensure continuity for residents through staff completing additional hours, and by regular agency staff covering a small number of shifts weekly. In line with the findings of the last inspection, the inspector found that staff rotas required review to ensure that staff's full names and roles were recorded on them. The majority of staff files contained the required information, however one agency staff's records did not, and this will be detailed later in the report.

For the most part staff were accessing training and refresher training in line with the organisation's policies and residents assessed needs. A small number of staff required training or refresher training and these will be detailed later in the report. There was regular formal supervision in place and evidence that each staff had supervision twice to date in 2021, with more sessions planned. Staff who spoke with the inspector said they were supported in their role and said they would call a member of the management team if they had any concerns.

Residents were protected by the admissions policies and procedures in place. They each had a contract of care which contained the required information. Residents were also protected by the complaints policies, procedures and practices in the centre and each resident who spoke with the inspector was aware of how to raise any concerns they may have.

Regulation 15: Staffing

There was one staff vacancy and the provider was in the process of recruiting to fill this post. It was evident that every effort was being made to ensure that residents were in receipt of continuity of care and support as staff were completing additional hours and a small number of regular agency staff were completing the remaining shifts.

In line with the findings of the last inspection, improvements were required to staff rotas. A number of rosters reviewed did not contain the second name or role of staff, and for some shifts covered by agency staff, the name of these staff were not included on the roster.

The inspector reviewed a sample of staff files and found that the files of regular staff members contained the information required by the regulations. However, one agency staff's file did not contain documentary evidence that they had completed safeguarding training, and did not contain a full employment history. Before the end of the inspection, the inspector was shown documentary evidence that this agency staff member had completed safeguarding training, and the PPIM was in the process of following up with the agency in relation to their employment history.

Judgment: Substantially compliant

Regulation 16: Training and staff development

For the most part staff were accessing training and refresher training in line with the organisation's policies and residents' assessed needs. However, a small number of staff required fire safety awareness training, managing behaviour that is challenging training, medication management and FEDS training.

There was a schedule in place to ensure that each staff member had regular formal staff supervision. Each staff member had had supervision at least twice in 2021.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider was self-identifying some areas for improvement, some of these had come up in a number of their audits and required action in order to ensure they were fully monitoring the quality of care and safety of care and support for residents and implementing the organisation's systems in relation to documentation and audit.

For example, staff meetings were not occurring as regularly as planned and there was no documentary evidence presented that audits were being completed regularly in the centre.

There had been a number of recent changes in the management structure and during the inspection the new person in charge and person participating in the management of the centre outlined plans to implement a number of systems to ensure consistency in the implementation od the provider's systems and in relation to documentation in the centre. These areas for improvement had been highlighted in a number of the provider's audits and reviews and were marked as complete in the latest six monthly review; however, this was not found to be the case during the inspection. In addition, there was an absence of dates for completion of actions in the latest six monthly review and for some actions the person responsible for their completion was not detailed in the report.

During the inspection there were some difficulties and delays in accessing some information. The inspector acknowledges that the location of the office had changed and that the person in charge and PPIM were new in post. However, once some of the documentation was sourced it was not found to be up-to-date, or fully completed.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Residents had contracts of care in place which contained the required information. There was an easy-to-read version of this available for residents and one resident in this centre had been involved in the development of an overview document which demonstrated the difference between the service's previous contract of care and the new one.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector was notified of all the required information in line with the timeframe identified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents were protected by the complaints policies, procedures and practices in the centre. There was a nominated complaints officer and systems in place to document and follow up on complaints.

Judgment: Compliant

Quality and safety

The inspector found that residents lived in a warm, clean and comfortable home. Overall, they were in receipt of a good quality, person-centred and safe service. The staff team were aware of residents' interests and wishes and motivated to ensure they were making choices in relation to how they wanted to spend their time. As previously mentioned some improvements were required in documentation relating to residents' finances, fire drills, and the oversight of risk in the centre.

There was a policy on residents' personal property and finances and residents were supported to manage their finances and keep their possessions safe. The provider was found to be recognising, reporting and appropriately following up on safeguarding concerns. They were developing and reviewing safeguarding plans, and implementing the control measures developed in these plans. However, the inspector found that one residents' financial assessment had not been updated to reflect their potential vulnerability to financial abuse following a reported incident in the centre, or to reflect a change in practice in relation to the storage of their money.

Overall residents were protected by the risk management policies, procedures and practices in the centre. The provider's risk management policy contained the required information and individual risk assessments were developed and reviewed as required. However, the inspector found that improvements were required in relation to the oversight of risk in the centre. There was a risk register but it was not found to be reflective of the actual risks in the centre and this will be further detailed later in the report.

Residents were also protected by the polices, procedures and practices relating to infection prevention and control. Staff had completed a number of additional infection prevention and control courses, and there were cleaning schedules in place to ensure that each are of their home was cleaned regularly. There was stocks of personal protective equipment (PPE), and systems in place to order more.

There was suitable fire equipment which was being regularly serviced. There was also adequate means of escape and emergency lighting in place. Residents had personal emergency evacuation plans in place which detailed any supports they may require to safely evacuate the centre in the event of an emergency. While fire drills had occurred in the centre, it was not documented who took part, what occurred

during the drill and whether any follow up actions were required after them.

Residents could freely access information in the centre on rights and accessing advocacy services. They were supported to exercise choice and control over their day-to-day life and were being involved in the running of the centre. They had opportunities to engage in activities in line with their interests.

Regulation 12: Personal possessions

Overall residents' personal possessions were respected and protected in the centre. They were being supported to retain control over their personal property and possessions, to manage their financial affairs and to manage their laundry. However, in line with a recent safeguarding concern in relation to a resident's vulnerability to financial abuse, their financial assessment had not been reviewed or updated to consider changes in practices and their support needs.

Judgment: Substantially compliant

Regulation 17: Premises

Residents lived in a warm, clean and comfortable home, which were designed and laid out to meet their needs. One resident had plans to complete a number of works in their room and the provider had plans to re-purpose what was previously an outdoor office, to make the best use of this space. They were also in the process of fixing the heating system in one residents' bedroom at the time of the inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall, residents were protected by the risk management policies, procedures and practices in the centre. The provider had updated the risk management policy and it now contained the information required by the regulations. However the risk register was not found to be fully reflective of the actual risks in the centre on the day of the inspection. For example, the Chief Inspector had been notified of a number of adverse incidents and safeguarding concerns in 2021 and the risk register did not reflect these. The inspector acknowledges that residents had risk assessments in place in relation to these risks and that arrangements were in place to ensure control measures were relative to identified risks.

Arrangements were in place to identify, record, investigate and learn from incidents

in the centre, and there were systems in place to respond to emergencies.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Residents were protected by the infection prevention and control polices, procedures as practices in the centre.

There were cleaning schedules in place to ensure that each area of the centre was regularly cleaned. There were stocks of PPE available and systems in place for stock control. Staff had completed a number of additional infection prevention and control related trainings during the pandemic.

Judgment: Compliant

Regulation 28: Fire precautions

There was suitable fire equipment provided and evidence that it was serviced as required. There were adequate means of escape and emergency lighting in place. The procedure for the safe evacuation of the centre in the event of an emergency was available and on display. Residents had personal emergency evacuation plans which clearly guided staff in relation to any support they may require to safely evacuate the centre.

Although fire drills were occurring, there was insufficient evidence to indicate who took part, or to demonstrate any learning or requirements for update of residents' personal emergency evacuation plans following these drills.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were protected by the safeguarding policies, procedures and practices in the centre. Staff had completed training and those who spoke with the inspector were aware of their roles and responsibilities. Safeguarding plans were developed and reviewed as required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted with and taking part in the day-to-day running of their home. They were making choices in relation to their care and support, including what they wished to spend their time doing. They were provided with information on how to access advocacy services, residents' rights, safeguarding, and complaints. These topics were also discussed regularly with their keyworkers and at residents' meetings.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Camphill Community of Ireland Greenacres OSV-0003623

Inspection ID: MON-0033731

Date of inspection: 14/09/2021

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 staffing levels have been reviewed within the community with another full-time staff member being allocated to the designated center. This has resulted in a substantial decrease in the need for agency staff in the service. • The PIC is based in the designated centre which further strengthens the team at Greenacres. • Recruitment for a relief panel which will further enhance the delivery of quality care in the community is underway. • A standard roster template has been introduced to the community which will ensure that all the required information is recorded • A full schedule 2 audit has been completed in the community and the PIC will ensure that all new starters have the required documentation at their commencement date	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff training has been reviewed and fire safety training and manual handling and moving has been completed. • Medication administration training is scheduled for completion on 20/10/21	

• Safeguarding training is scheduled for completion on 03/11/21
• Studio 3 training has also been booked, confirmation of dates to be issued by the provider
• The PIC will ensure that the annual supervision schedule is completed with the staff team.
• Understanding HIQA Regulations training is also taking place for the community on the 2/11/2021.
• The PIC will review the training tracker monthly and ensure training is scheduled who are onboarding or require refresher training

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A new Person in charge (PIC) joined the organization (06/09/2021).

• The annual supervision schedule is in place for all staff and being reviewed by Person in Charge on a monthly basis, supervision is also provided by the Regional Manager to the PIC on a monthly basis

• There is an operational line management structure in place to oversee the management of the service, this structure supports service delivery from local level to national level across the organisation. The organisation is committed to ongoing oversight completing unannounced visits every six months and conducting an annual review of the service.

• Following each Internal and External announced and unannounced inspections, Annual Reviews and Health & Safety Audits the Person in Charge will ensure that all follow up actions identified are completed in a timely manner and integrated into the Centre's Community Improvement Plan which is maintained on a shared database with oversight from a local, regional, and national level.

• The Person in Charge and the Regional Manager will review the progress of the centre against the Centre's Community Improvement Plan on a monthly basis

• The Person in Charge will conduct weekly, monthly, quarterly, six monthly and annual audits regularly for oversight of the designated centre and oversight on records.

• Weekly meetings are in place and records are uploaded to the community shared database (Sharepoint) which has oversight form a local, regional, and national level. All action will be escalated to the Person in Charge immediately where required.

• Monthly Community team meetings with regional manager, clinical team, and regional

safeguarding team are in place. These meetings have an agenda that includes review of individual resident needs, safeguarding concerns, accidents/incidents, complaints, health and safety concerns, staff training needs and maintenance.

• Documents are uploaded to SharePoint where the Person in Charge ensures daily oversight on all records of work completed in each house including residents' daily notes, incidents and accidents and financial transactions pertaining to each resident. The Greenacres SharePoint site is accessible to and is overseen by the local Management team, Regional Manager and relevant national teams.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• The Money Management assessment has been reviewed and updated for one resident in line with their support plans
• Daily and monthly oversight and reconciliations are taking place at local community level and with remote auditing taking place at regular intervals

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The risk register has been updated to include all risks identified within the community, this is reviewed regularly with the PIC, Regional Manager and Safety and Risk Manager
• The risk register is reviewed regularly with staff at community management meetings. Staff have been made aware of their duty to report all Quality and Safety incidents which are reviewed at Community team meetings.
• A Health and Safety/Fire Safety Audit has been completed by an external contractor at Greenacres

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Greenacres have fully implemented the CcoI fire safety processes and evidence is recorded in the fire folders for each house
• A review and update of the personal emergency Evacuation plan of each resident has been completed
• A Health and Safety/Fire Safety Audit has been completed by an external contractor at Greenacres
• A schedule of Fire drills is in place for the remainder of the year

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/10/2021
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/10/2021

Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/10/2021
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/10/2021
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	31/10/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/10/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent	Not Compliant	Orange	30/11/2021

	and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/11/2021
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	31/10/2021