Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Special Dementia Unit - Sonas Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	18 October 2022
Centre ID:	OSV-0003746
Fieldwork ID:	MON-0037075

About the designated centre

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

The designated centre is based on a campus setting in suburban area of North-West County Dublin and provides specialist dementia care to persons with intellectual disabilities some of whom have end of life support needs. The centre is comprised of one large building which was constructed in 2013 and currently operates as two separate units within the one premises. Services are provided through 13 long term beds and one respite bed. There is a staff team of clinical nurse managers, staff nurses, care assistants and household staff employed to support residents and additional supports are provided through volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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 18 October 2022	09:15hrs to 16:30hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This unannounced inspection took place to monitor ongoing regulatory compliance. The inspector found that residents were living in a purpose- built centre which was a pleasant environment designed to best support their assessed needs. Residents were seen to be comfortable and content and interactions between residents and staff were person-centred, responsive and kind.

Following a number of inspections on the campus where this designated centre is situated, the provider was invited by the Chief Inspector to a cautionary meeting. Following this, the provider submitted an improvement plan to address areas of non-compliance across the campus in May 2022. As part of this plan the provider committed to a number of actions to come into compliance with regulations which included staff training and development, general welfare and governance and management. The inspector found that while some areas in this designated centre had improved since the last inspection took place, there were a number of areas which continued to be non-compliant such as staffing, staff training and development, governance and management, medicines management and safeguarding.

The designated centre is located on a campus. It was purpose-built in 2013 and provides dementia care to residents with intellectual disabilities, some of whom require end-of-life care. It is a wheelchair accessible building which is divided into two units. One of the units is an eight- bedded unit which provides long-term specialist care to seven residents living with dementia. There is a respite bed on this unit which was re-opening on the day of the inspection, following a closure during the COVID-19 pandemic. During the pandemic, this bed was used to provide support to a resident with complex medical needs. The second unit has six beds and provides care to residents with advanced dementia, including end-of-life care. The service is a nurse-led service and had specialist input from clinical nurse specialists in dementia. These clinical nurse specialists had a national remit and worked in partnership with a local hospital and university in addition to providing in-house assessments and supports to those living with dementia. The staff team also consisted of care assistants, house hold staff and a laundry staff.

The inspector did a walk through of the centre in the company of the person in charge and briefly met with or observed residents. A number of residents were observed from a distance and were asleep in bed or in their chairs during the inspection. All of the residents appeared well cared for and comfortable. The inspector also interacted with staff members and members of the clinical support team. Some of the residents were sleeping or resting during the day. Others were up and enjoying activities such as colouring and listening to music. Another resident was walking around both of the units and chatting with staff members. The resident enjoyed doing chores in the centre and was supported to do so. For one resident who had recently moved into the centre, they spoke with the inspector about jobs they used to do while colouring with staff. Another resident was supported to listen

to their favourite music on their tablet. Residents were supported to access activities and go out shopping or for coffee or a walk. One resident had celebrated their birthday in a hotel and enjoyed staff talking about it. They walked around the centre and briefly interacted with the inspector throughout the day.

Residents right to privacy and dignity was promoted through the use of a simple visual on each door with green and red on either side and this was respected by staff on duty. There was a calm and relaxed atmosphere in the centre. Staff members who the inspector met with and observed were noted to treat the residents with kindness and interactions were friendly and respectful. There was music playing softly in one part of the centre and noise was kept to a minimum.

Residents had access to a range of health and social care professionals such as a GP, speech and language therapy, occupational therapy, physiotherapy and clinical nurse specialists in dementia. They accessed alternative therapies such as dementia specific aromatherapy and relaxation sessions and massage. There was a chaplain available on the campus to provide spiritual support and care to residents, families and staff, where appropriate. Other activities available to residents were music sessions, baking, circle dance, flower arranging and bingo. Residents went for walks on the campus with staff members and had a weekly quality- of -life timetable.

In summary, from what the inspector observed and what those observations demonstrated about residents' day-to-day life, it was evident that residents' were well cared for by a staff team who were familiar with their assessed needs in a suitable and pleasant environment. The next two sections of the report discuss the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Governance and management arrangements in the centre were found to have been ineffective in monitoring and overseeing the quality and safety of care of the residents. There had been a change in the person in charge three times over the past year and a change to the persons participating in management three times in the same period. Many of the actions identified on the centre's inspection in June 2021 remained outstanding. However, the provider was in the process of stabilising both the management team and the staff team. The person in charge commenced the week prior to inspection and were beginning to ascertain required actions to bring the centre back into compliance.

There were two staff vacancies on the day of the inspection. The inspector viewed rosters for the month prior to the inspection. These were poorly maintained. It was not possible to ascertain if all shifts had been filled and who had completed shifts from the relief panel or agency. A staffing review was due to take place to ensure that safe staffing levels were maintained to meet the assessed needs of all residents living in the centre. This was identified in April as an action but had not yet been

completed.

A review of the staff training matrix indicated that there were significant gaps in staff training and development, which posed a risk to residents. A training needs analysis was carried out in June 2021 and identified a number of gaps, notably in palliative care and syringe drivers for nursing staff, the use of Albac mats and managing feeding, eating, drinking and swallowing difficulties. Staff supervision arrangements had improved and most staff had completed one supervision session with a member of management

A review of incidents and accidents in the centre indicated that the provider had notified the office of the chief inspector of adverse incidents in line with regulatory requirements.

Regulation 15: Staffing

A number of staff had been recruited since the last inspection. Four new staff members had commenced duty the week of the inspection, with another two staff due to commence over the following month. The inspector found that rosters were poorly maintained. Where there was agency or relief staff booked for shifts, their names were not always recorded and it was not possible to ascertain if all of the shifts required were filled. For example in a two week period, there were 15 shifts with no named staff recorded as having completed shifts. From documentation reviewed, there was evidence that concerns were raised by staff on the staffing levels as part of the provider's six monthly audit in April 2022. A 'safe working staff to resident' ratio was documented as being higher than current staffing levels. Another identified action in April 2022 was that a review of staffing levels was to take place but this was not completed. This was of particular concern due to the dependency levels and specific care needs in the centre in areas such as personal care, eating and drinking, manual handling and safeguarding.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of the staff training matrix indicated that there were significant gaps in staff training and development, which posed a risk to residents. A training needs analysis was carried out following an inspection in June 2021 and this identified a number of gaps, notably in palliative care, dementia, syringe drivers for nursing staff, the use of Albac mats and managing feeding, eating, drinking and swallowing difficulties. Dementia training was since complete for most of the staff team, with the remainder due to complete this training in the weeks following inspection. This training also provided staff with required knowledge on responding to responsive

behaviour for residents with dementia. All staff had completed mandatory training in safeguarding, fire safety and infection prevention and control. Of particular concern was the gap in medication management training. Twenty percent of the nursing staff had not completed the course, one staff member was three years out-of-date and thirty percent of staff were out of date within the past few months. There was a plan in place for nursing staff to complete this training by December 2022. Arrangements for the supervision of staff had improved since the last inspection , with most staff members having completed one supervision session this year and a schedule was in place to complete the remainder of outstanding sessions.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and management arrangements in the centre were found to be ineffective in ensuring adequate monitoring and oversight of the quality and safety of care of the residents. There had been a change in the person in charge three times over the past year and a change to the persons participating in management three times in the same period. However, the provider was in the process of stabilising both the management team and the staff team. The person in charge started in the centre a week prior to the inspection and there were five new staff due to join the team in the weeks following the inspection.

The annual review for 2021 was in progress on the day of the inspection. Reports from the provider's six monthly unannounced visits in 2021 were not available. The inspector viewed the six monthly visit carried out in 2022 and this indicated that the provider was self-identifying areas requiring improvement and developing action plans. However, it was unclear what the status of these actions were. There was a schedule of audits in place in order to provide monitoring and oversight of the quality and safety of care in areas such as risk management, staff training and care plans. Similarly, it was unclear whether these were completed in line with the provider's timelines and whether actions had been identified.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had notified the office of the chief inspector of adverse events in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the quality and safety of care provided for residents was of a high standard. They were in receipt of person-centred care and were living in a comfortable and spacious home which was well suited to their current and future needs. Interactions and care given to residents that were observed on the day of the inspection were noted to be kind and responsive. Residents in the centre were supported to have best possible health. They had access to a range of health and social care professionals. Residents had dementia-specific care plans in place in line with dementia-care standards. Residents were supported to access national screening programmes where appropriate and to de-consent where appropriate with input from the person, family and the multidisciplinary team. End-of-life care planning was in place in relation to resuscitation status and transfer to hospital.

There had been a high number of safeguarding notifications received in the months prior to the inspection which related to physical interactions occurring between residents. These incidents were appropriately recognised, reported, documented and investigated in line with national policy. Safeguarding plans were developed for residents and a safeguarding log was held by the person in charge. However, due to staffing concerns outlined earlier in the report, it was not clear whether some of the control measures relating to supervision were achievable and therefore, that residents were protected from abuse. This risk was to be further impacted by the re-opening of the respite bed in addition to vacant beds being filled in the weeks following the inspection.

Residents in the centre were supported to receive visitors in line with public health guidance. Where a resident was in their final days, family were facilitated to stay with them, where they wished to do so. There was a family room available in the centre. There were a number of spaces in the centre available to residents to use with visitors, in addition to facilities on the campus. The inspector observed family members being supported by staff in the centre on the day of the inspection.

Residents in the centre were supported to maintain good dietary intake and hydration. They had input from a dietitian and speech and language therapy where it was required. Food came from a central kitchen located on the campus and was ordered in advance. Staff were familiar with residents' dietary needs and preferences and modified their food in the centre. For other residents, they were supported to buy, prepare and cook some meals. There were adequate supplies of snacks available.

The provider had a system in place for the identification, assessment and management of risk within the centre in addition to a risk management policy. Incidents were trended on a monthly basis and where required , risk assessments were developed. However, the risk register had not been reviewed in line with the provider's time lines and was not reflective of the risks in the centre at the time of the inspection. Where adverse incidents occured, these were reported and

documented appropriately. Documentation of incidents included identifying any learning from events and these were shared with the staff team.

The provider had good fire safety management systems in place to protect residents and staff in the centre. There were fire doors, fire-fighting equipment, emergency lighting and detectors throughout. Each resident had a personal emergency evacuation plan in place. Documentation relating to drills required improvement in order to demonstrate that safe evacuation of residents was achievable with the minimal staffing complement.

Medication management required improvement to ensure safe practices in the designated centre. As stated previously, only one staff nurse had training which was in date in relation to medication management. The centre was found to have appropriate practices in relation to ordering, receipt, disposal and administration of medication. Controlled drugs and out-of-date drugs were appropriately stored and checked each day. An audit of each residents' MPARs record was carried out each week in addition to a medication audit. However, the inspector found a large quantity of thickening agent and a large range of dietary supplements stored on open shelves in the pantry.These were not labelled with residents names in spite of being prescribed.

Regulation 11: Visits

Residents in the centre were supported to receive visitors at reasonable times and in line with public health guidance. Where a resident was in their final days, family were facilitated to stay with them, where they wished to do so. There was a family room available in the centre. There were a number of spaces in the centre available to residents to use with visitors, in addition to facilities on the campus.

Judgment: Compliant

Regulation 17: Premises

The premises is a purpose-built centre for residents living with dementia and the design and layout was found to promote residents' safety , dignity and independence. On the day of the inspection, the centre was found to be warm, homely and tastefully decorated. There were a number of minor works required to continue to maintain the centre to a high standard and to ensure appropriate storage spaces for larger items, but these were all identified by the provider and in progress. Residents had private and communal accommodation which had adequate spaces for private, social, recreational activities and dining. Residents had access to an internal courtyard within the centre and all residents had their own bedroom and bathroom.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents in the centre were supported to maintain good dietary intake. They had input from a dietitian and speech and language therapy and other health and social care professionals where it was required. Food came from a central kitchen located on the campus and was ordered in advance. Many of the residents were on a modified diet and thickened fluids in addition to requiring dietary supplements. Staff were familiar with residents' dietary needs and preferences and food was modified within the centre. Some residents were supported to purchase and cook meals where they wished to do so. There were adequate supplies of snacks available. Residents were supported to eat and drink in line with their required needs each day. For example, some residents were supported to have breakfast in bed and others were supported to eat in the dining room. At lunchtime, many of the residents were asleep and staff supported them when they were alert enough to eat and drink. The inspector observed two residents being supported at a mealtime. In both cases, staff feeding residents were noted to support residents in a calm and unhurried manner. The meal was observed to be calm and relaxed and promoted residents' dignity and independence.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a system in place for the identification, assessment and management of risk within the centre. Incidents were trended on a monthly basis and where required ,risk assessments were developed. For example, for recurrent bruising of a resident, a risk assessment was completed in addition to a care plan being put in place. However, the risk register had not been reviewed in line with the provider's time lines and was not reflective of the risks in the centre at the time of the inspection. Where adverse incidents occured, these were reported and documented appropriately. Documentation of incidents included identifying any learning from events and these were shared with the staff team.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had good fire safety management systems in place. There were fire

doors, fire fighting equipment, emergency lighting and detectors throughout. Daily and weekly checks of equipment were also taking place. Each resident had a personal emergency evacuation plan in place. Documentation relating to drills required improvement. While there were drills taking place, it was unclear what method of evacuation was used for example, by bed, by foot or using an Albac mat. No learning was identified from ten drills which were reviewed. Some of the drills did not have evacuation times on them. It was therefore unclear if safe evacuation of residents was achievable with the minimal staffing complement.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medication management required improvement to ensure safe practices in the designated centre. As stated previously, only one staff nurse had training which was in date in relation to medication management. The centre was found to have appropriate practices in relation to ordering, receipt, disposal and administration of medication. Controlled drugs and out-of-date drugs were appropriately stored and checked each day. An audit of each residents MPARs record was carried out each week in addition to a medication audit. However, the inspector found a large quantity of thickening agent and a large range of dietary supplements stored on open shelves in the pantry. Residents names were not on these items. The inspector received assurances following the inspection that this had been rectified, with items stored in a locked press and appropriately labelled with residents' names who had a prescription for these supplements or products.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a range of health and social care professionals such as a GP, speech and language therapy, occupational therapy, physiotherapy and clinical nurse specialists in dementia. They accessed alternative therapies such as dementia specific aromatherapy and relaxation sessions and massage. Residents had dementia specific care plans in place in line with the National Dementia Standards and these plans were informed by a multidisciplinary team. Residents had hospital passports in place to ensure that all relevant health information was easily accessible in the event of an emergency. Residents were supported to access National Screening Programmes where appropriate and to de-consent where appropriate with input from the person, family and the multidisciplinary team. Residents' preferences and supports in relation to end-of-life care were considered and placed in a prominent position in their care plans. These included discussions

relating to transfer to hospital for residents and resuscitation status.

While there was a requirement for documentation to be updated in some residents' plans, the provider had identified this and were in the process of ensuring a review of residents' care plans were taking place.

Judgment: Compliant

Regulation 8: Protection

There were a high level of notifications to the Authority of safeguarding concerns in the 12 months prior to the inspection. These incidents were appropriately recognised, reported, documented and investigated in line with national policy. Safeguarding plans were developed for residents with input from the multidisciplinary team and a safeguarding log was held by the person in charge.

Due to staffing concerns outlined earlier in the report, it was not clear whether some of the control measures relating to supervision were achievable and therefore, that residents were protected from abuse at all times. A complaint had been received from a family member on behalf of their relative in relation to the incidents taking place in the centre. The risk of incidents occurring would remain as long as some of the residents lived together. This risk may be further impacted by the re-opening of the respite bed in addition to vacant beds being filled in the weeks following inspection.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Special Dementia Unit - Sonas Residential Service OSV-0003746

Inspection ID: MON-0037075

Date of inspection: 18/10/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Currently 0.5 Staff Nurse vacancy in the centre, Same has been successfully recruited and awaiting commencement date. The Registered Provider and Person in charge will ensure that appropriate staffing numbers and skill mix are rostered within the Centre and the allocation of resources is flexible to meet the needs of the residents. Rosters will be maintained by the person in charge to ensure they contain required information including as outlined in the regulation including names of Relief and Agency staff.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A full Training needs analysis has been completed by the PIC to identify training requirements for the Centre. All staff will be supported to attend training as identified on the Training Needs Analysis and a record of same will be maintained in the local training log and monitored on an ongoing basis. All staff nurses will complete HSELand medication management.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
All audits and six monthly provider reports will be reviewed by Person in Charge. Status of actions will be ascertained, reviewed and updated on a monthly basis by the PIC.
The Provider will ensure six monthly unannounced visits are carried out in line with regulation.
The provider will ensure improved governance systems are in place to provide oversight of the Centre to include monitoring of actions from all audits including provider visits and annual reviews.

A Governance & Oversight group including members of the executive team has been established to monitor and oversee implementation of a plan to address areas of non compliance and ensure delivery of quality person centered supports to a high standard.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Registered Provider will ensure all risks within the Centre are identified, assessed, managed and reviewed.

The risk register will be updated to ensure that it is reflective of all risks in the Centre and will be reviewed on an ongoing basis in line with provider's time lines.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider will ensure Fire drill reports will record the method of evacuation for each resident, time to complete the drills, any issues identified during the evacuation and actions required to address issues

A Fire drill will be undertaken with minimal staffing compliment to ensure safe evacuation is achievable.

Learning from Fire drills will be shared with staff team via daily Safety Pause and Staff Meetings.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All staff nurses will complete medication management.
All Prescribed Thickening agents and supplements are labeled with resident names and stored in a locked press. This was implemented on day of the inspection.

Completed by 31/11/22

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A comprehensive review of all safeguarding incidents is in progress; this review includes date, time of incident, vulnerable persons involved, triggers, location of incidents and number of staff present at the time of incident.
Safeguarding plans are also under review to ensure safety of all Residents at all times.
All safe guarding plans/ control measures are discussed at safety pause and staff meetings.
Safeguarding will be reviewed every three weeks or as required by MDT team.
Allocation of staffing resources on the roster will be reviewed daily to ensure it is flexible to meet the needs of the residents. .

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/03/2023
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.	Not Compliant	Orange	30/11/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Not Compliant	Orange	30/04/2023

	as part of a continuous professional development programme.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/01/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/12/2022
Regulation 28(4)(a)	The registered provider shall make arrangements for	Substantially Compliant	Yellow	31/01/2023

	staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/12/2022
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre	Not Compliant	Orange	30/11/2022

	is stored securely.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2022