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:	Comeragh Residential Services Kilmacow
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	26 July 2023
Centre ID:	OSV-0005089
Fieldwork ID:	MON-0039923

About the designated centre

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

Comeragh Residential Services Kilmacow is a designated centre operated by Brothers of Charity Services Ireland CLG. It provides a high support residential service for up to seven adults, of both genders with intellectual disabilities. The designated centre is located in a village in Co. Kilkenny located close to local amenities such as post office and shop. The designated centre is a large bungalow which consists of seven individual resident bedrooms, a kitchen, a dining room, a sitting room, a lounge and a laundry room. Staff support is provided by nurses, social care leaders, social care workers and care assistants. The staff team are supported by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 26 July 2023	08:00hrs to 16:00hrs	Sarah Mockler	Lead
Wednesday 26 July 2023	08:00hrs to 16:00hrs	Conan O'Hara	Support

What residents told us and what inspectors observed

This inspection was completed by two inspectors, over one day, to follow up on areas for improvement as identified on previous inspections. Registration of this centre was renewed in April 2023 with an additional condition applied that required the centre come into compliance with named regulations by 10 October 2023. This inspection took place prior to this date to determine progress towards compliance.

The findings of this inspection indicate that levels of compliance overall remained very poor. There remained a number of issues with resident compatibility and staffing that was impacting on the lived experience of residents. In addition, the provider failed to evidence whether plans or other improvement initiatives were in place to ensure they would reach the requirements of regulation within the time frame specified by the registration condition.

As per previous inspection findings, the resident group living in this centre were assessed as not being compatible to live together. For example, residents with dementia, autism and other mental health presentations were clearly and frequently triggering each others behaviours resulting in incidents or outbursts. This led to a general approach/culture of keeping residents away from each other. This raised a number of challenges for the residents living in the centre and the staff team in terms of the day-to-day care and support being provided. Although, the concerns regarding compatibility of the resident group was well identified by the provider, compatibility assessments had only been recently formally completed. These formal assessments further demonstrated and reinforced the compatibility issues within the centre. This is discussed in the relevant sections of the report.

Inspectors had the opportunity to meet with all seven of the residents who lived in this centre. Inspectors observed the care provided and met with the staff and management on duty. Discussions with staff, observations, and documentation review were utilised across the inspection day to gather a sense of what it was like to live in the centre.

Inspectors noted that some improvement was in place around access and participation in social activities. In addition, the standard of staff and resident interactions was more meaningful and person centred. On the day of inspection, some residents left the centre and other residents had a music therapy session. From a review of relevant documentation, the provider was able to demonstrate an increased focus on ensuring residents were getting out into the community and engaging in in-house activities that were being offered. For example, the documentation demonstrated that residents went on drives to local amenities, attended retirement groups, met with family members and engaged in in-house activities including reflexology and music. However, although improvements were noted, this was an area that required continued focus and improvement. Staff stated they were still trying to ascertain residents preferences around activities and at times the variety of activities being availed of by residents was repetitive in nature.

For example, a resident went on a drive to the same location across a number of weeks.

The designated centre is a detached bungalow which comprises seven individual resident bedrooms, a kitchen, a dining room, a sitting room, a parlour room and a laundry room. In response to the areas for improvement identified in January 2023, the provider had committed to assigning an empty bedroom as a sensory room in order to afford additional communal spaces for the residents. The provider submitted the relevant information into the Office of the Chief Inspector to change the floor plans to reflect this. The inspectors had the opportunity to review this space on the day of inspection and found that this room was not fit for purpose. For example, the room contained an ironing board with an iron, a clothes horse and a chair weighing scales. There was no sensory equipment set-up in the room or no areas assigned for seating. The provider did not have any tangible plans available to review or timelines on when this space would be converted to an additional communal space. This was directly impacting on residents. As previously stated, residents were not compatible to live together and some residents were not permitted to be in the same communal space when others were present. This meant that residents had to be brought to their bedrooms to allow for space from each other. For example, three residents were present in the sitting room. A resident began to use loud vocalisations and bang doors. In order to minimise the impact of this, this resident was brought from the sitting room to their bedroom as there was no other free communal space available.

Residents' rights continued to be negatively impacted due to the ongoing compatibility issues of the resident group. The residents had limited choice and control to where they could spend their time in the home. For example, meal times were staggered. While the issues with the compatibility of the resident group had been well identified by the staff team and management and measures had been put in place to keep residents safe, there was an ongoing negative impact to a number of residents within the home. For example, on review of the complaints log, there were a number of recent complaints from 2023, submitted by residents, indicating they were unhappy with the noise level within the home. A similar pattern of complaints was also noted in 2022.

Residents were supported by a staff team which comprised of nursing staff, social care workers and care staff. Residents were assessed to require a high level of support and the staffing numbers in place reflected this. However, there was a reliance on agency staff within the centre which directly impacted continuity of care.

In summary, based on what the residents communicated and what was observed, it was evident that basic care needs were being met and some improvement was noted in relation to access to activities. However, the provider was failing to meet the requirements of regulation in relation to residents' rights, meeting residents' specific assessed needs, staff resourcing and the training and development of the staff team.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place

impacted on the quality and safety of the service being delivered.

Capacity and capability

This centre had been inspected on two occasions in 2022 and again in early 2023. Across these three previous inspections a number of areas of improvement had been highlighted to the registered provider including the poor compatibility of the resident group. Overall the findings of this inspection indicated that significant improvements were still required in a number of areas. Although areas for improvement had been identified by the provider, the measures implemented to date to address same had not been effective. The findings indicated that the residents lived experience continued to be negatively impacted.

There was a clear management structure in place. The centre was managed by a person in charge who had recently been appointed. The person in charge was on annual leave on the day of the unannounced inspection. Although newly appointed to this role, they had been seconded to the centre as a social care lead prior to this. Clinical oversight in the centre was provided by the Clinical Nurse Manager (CNM3), who was also appointed as the person participating in management of the centre. The CNM3 facilitated the inspection. They were present in the centre on a regular basis.

Previous inspections had identified a need for improvement in the effective oversight and governance of this centre. The majority of residents' assessed needs indicated that they needed a quiet, low arousal environment. This was not always possible due to the specific needs of residents within the home. This had been identified by the provider as far back as 2018 and limited effective actions had been put in place to address this. A formal compatibility assessment had been completed by members of the staff team and the psychology team indicating that the majority of residents were not compatible to live together. This is discussed further under Regulation 5. On the day of inspection, the provider had no plans in place on how this would be addressed to a meaningful degree.

Regulation 15: Staffing

There remained a heavy reliance on agency staff in this centre which was leading to inconsistent care. Agency staff accounted for approximately 30% of the staff team with a number of agency staff present each day. The provider had a list of 10 agencies that they could utilise if staff were required. On the day of inspection, there were a number of agency staff on duty.

At times, some agency staff could not drive the centre vehicles nor administer medications which significantly impacted how on activities and some care needs

could take place in the centre. For example on the day of inspection, a resident refused help from an agency staff to assist them with their meal time routine. Regular staff explained that the resident required a consistent staff member to ensure this routine could be effectively completed. This resident had very specific needs and risks associated with this routine which highlighted the importance of using a consistent staff team.

There were a number of documented times when there were no staff present in the building that had specific training in medication administration.

Judgment: Not compliant

Regulation 16: Training and staff development

There continued to be a deficit in staff training. From a review of training records, members of the staff team required initial training or refresher training in a number of areas including managing behaviour that challenges, first aid, manual handling, safe administration of medication, diabetes, and infection prevention and control trainings.

In addition, staff supervision was not sufficient considering the needs of the residents and the challenges posed in the centre. The provider's supervision policy stated that one formal one-to-one supervision meeting was to occur on a yearly basis. This was not sufficient. Furthermore, on a review of a sample of supervision records, it was evident that a number of staff had not received supervision in line with the provider's policy.

Judgment: Not compliant

Regulation 23: Governance and management

There continued to be a lack of progress in the centre to address a number of previously identified issues. This did not demonstrate effective governance and oversight. The ongoing issues of resident compatibility and the lack of provision of a consistent and core staffing team was impacting on residents care and support. On the day of inspection, it was not demonstrated to the inspectors on how this was going to be resolved by October 2023 as per the registration condition. The information provided to inspectors did not provide assurances that the identified issues were in the process of being rectified.

Significant issues remained that resulted in continued failings in terms of compliance with Regulations which translated to poor lived experience for residents. The systems in place for oversight were not driving necessary quality improvements. The

following as identified in the previous inspection continued to be the main findings of the current inspection:

- Care delivery was not occurring in line with all residents assessed needs.

- Staffing, staff deployment,and staff skill mix was not appropriate.

- Staff training, induction, supervision and development was of a poor standard.

- The standard and promotion of residents rights in this centre was poor with the provider self-identifying institutional type practices occurring within the centre.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that a number of actions continued to be required to ensure the provision of good quality care and support to residents living in the centre. Although some minor improvements had occurred, such as presentation of the premises and access to both in-house activities and community activities, the core issue of the incompatibility of the resident group still remained. This had not been effectively addressed despite being identified as an area for improvement by both the provider and previous inspection reports.

Due to the lack of progress in the previously stated key areas of compatibility and staffing resources, compliance was not being achieved in other areas particularly in relation to residents rights'. Residents had limited choice and control in terms of their day, as some residents could not spend time in each others company due to identified safeguarding risks. Residents' right to live in a home that met their assessed needs was not always possible. There was documented evidence that the noise level in the home impacted on other residents, this was clearly evidenced by for example, residents making complaints.

Regulation 13: General welfare and development

The previous inspection found that residents engaged in limited levels of activation, interaction and social engagement in their lives.

Notwithstanding, the concerns regarding compatibility of the resident group which is outlined under Regulation 5: Individual assessment and personal plan, the inspectors reviewed a sample of documentation which demonstrated an increased focus by the staff team and provider on ensuring residents had the opportunity for activation, interaction and social engagement in their lives. Residents were

supported to go on drives to local amenities, attend retirement groups and meet with family members. In addition, residents engaged in in-house activities including reflexology and music. The inspectors observed positive and appropriate interactions between the residents and the staff team.

While, it was demonstrable that there was an increased focus on residents' general welfare and development, this area required further improvement to meet the residents needs at all times.

Judgment: Substantially compliant

Regulation 17: Premises

The residents lived in a large detached bungalow. Each resident had their own bedroom and en-suite bathroom. Residents had some personal items on display in their bedrooms. Some recent works had been completed to ensure the centre was more homely in presentation. This included the purchasing of new furniture, soft furnishings and adding new lighting.

However, some residents spent large proportions of their day in their bedrooms and use of communal spaces had to be staggered to ensure that residents did not impact each other. This was in part due to the differing assessed needs of residents and the compatibility concerns which will be further addressed under Regulation 5: Individual assessment and personal plan and Regulation 9: Residents' Rights. The provider had previously committed to converting an unused bedroom to an additional communal space. The provider had identified that a sensory room was required. On the day of inspection, the inspectors found that this room was not fit for purpose as it was being utilised as another space to complete laundry. An ironing board and clothes horse were observed in this room with little other furniture. There was limited evidence on how this space was going to benefit the residents as they could not use it in its current design and layout.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The previous inspection found that this centre was not operating in a manner that was suitable to meet the assessed needs of all residents. In response to the findings of the last inspection, the provider explored an alternative placement for one resident which was later deemed not to be viable. The provider had also completed a medical review for one resident.

The inspectors found that the centre continued to be operating in a manner that

was not suitable to meet the assessed needs of all residents. The inspectors were directly informed about, reviewed supporting documentation/correspondence and directly observed compatibility issues between residents in this centre. For example, residents assessed as requiring quiet/low arousal environments were not being provided with this as they were living with residents who screamed and/or shouted at regular intervals.

The provider had recently completed compatibility assessments for all seven residents in the designated centre. These were completed by the provider's psychologist with the input of the staff team. These assessments indicated that two residents were not compatible to live with any other resident within the centre. All other residents were assessed to be incompatible with a number of other residents within the home. On the day of inspection, the psychologist came out to discuss the outcome of the assessments with the service manager. Overall, these formal assessments confirmed that the resident group were not compatible to live together in one designated centre. The provider had identified this via informal assessments previously.

Judgment: Not compliant

Regulation 9: Residents' rights

As identified in previous inspections, residents' rights continued to be an area that required a number of improvements. Again, the inspectors found that limited effective measures had been taken to address this to a meaningful degree.

Residents' choice and control was impacted by the incompatibility of the resident group in a number of areas, such as the use of the communal areas in the home. Also residents meal times continued to be staggered and not all residents could access other communal spaces within the home when other residents were present. The inspectors reviewed on-going complaints around the noise levels within the home and incident records noting residents stating they were not happy with the level of noise.

It was also documented that residents were spending large proportions of their day in their bedroom. Observations on the day of inspection also indicated this was occurring. For example, one resident was removed from the sitting room. They had become upset and were engaging in loud vocalisations and banging doors. They were brought to their bedroom with the support of staff. They remained in their bedroom as there was no additional communal space for them to avail off. They left their bedroom once it was time to leave the centre.

In addition, the provider six-monthly audit and multi-disciplinary team meetings identified that institutional type care was being provided to some residents within the home. This included residents going to bed at set times with no regard to their specific preferences or wishes.

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
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Comeragh Residential Services Kilmacow OSV-0005089

Inspection ID: MON-0039923

Date of inspection: 26/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• Despite significant efforts to address vacancies in this centre there continues to be a national staffing crisis which has impacted on our success to recruit staff. In an ongoing effort to address this, recruitment for this centre is being prioritised by the HR department and Management Team in an effort to fill vacancies that currently exist. An open day, facilitated by HR is being planned to support this.

• A review of the roster has been completed since the time of this inspection by the PIC and Service Manager with some staffing hours adjusted to better meet the needs of residents. As part of this roster review there is a consistent presence of at least one staff trained in medication administration at all times.

• While the Provider has an approved list of agencies, with whom there are SLAs, this centre is endeavoring to consistently use one agency provider to ensure there is a consistent, familiar support team in place. The PIC is committed to ensuring that any agency staff utilized in this centre meet the criteria to drive company vehicles.

• There remains a reliance, albeit reduced in recent months, on utilizing agency staff. While we continue to recruit permanent staff and endeavor to reduce agency use the PIC will ensure that robust inductions are carried out with agency staff. In addition to this, the PIC and CNM1 will carry out formal supervision with regular agency staff who work in this centre.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Provider has planned for all staff to have completed required training by year end. A number of trainings have been scheduled in consultation with the Training Dept:
• 7 staff have been scheduled to complete safeguarding training.
• 10 staff have been scheduled to complete safety intervention training to support staff in the management of challenging behaviors.
• 12 staff are scheduled to attend training on catheter care.
• 4 staff are scheduled to attend fire training.
• 3 staff are scheduled to attend manual handling.
• Staff requiring training in IPC will access this through HSELand training online.

A training needs analysis will be completed to ensure that any gaps in training are identified for planning purposes through 2024.

The PIC will commit to providing two scheduled staff support meetings with all team members, annually. Where a need for additional supervision is identified for a staff this will be scheduled as required.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Plans in relation to staffing are addressed under Regulation 15

• The Provider has planned for all staff to have completed the required training by year end

• The PIC will commit to providing two scheduled staff support meetings with all team members, annually. Where a need for additional supervision is identified for a staff this will be scheduled as required

• In line with our commitment to ensuring residents rights is at the forefront of service delivery a number of actions have been taken by the PIC such as

o Roster reviews with times of staffing shifts adjusted to better meet the needs of residents
o Implementing activity schedules for residents and introducing new activities/opportunities for community engagement
o The development of a sensory room for residents within the centre
o A review of the night time routines of residents and night shift planner
o A commitment to utilize regular agency staff where necessary who are familiar with residents care needs and can drive the company vehicles

• The provider is committed to transitioning one resident to a more appropriate location in line with their assessed needs. Since the time of this inspection, there have been a number of steps taken to progress this and a transition plan will be developed to ensure that this occurs at a pace that is in line with the residents assessed need.

• As part of a roster review the 1:1 staffing hours have been adjusted of for one individual who at times in the past has impacted on others due to loud vocalisations. Due to the changing needs of this individual and a significant reduction in incidents in which people have been impacted, the Provider is committed, in line with this individuals will and preference to continue to support this individual to reside at the centre.

• It is not currently possible to address all compatibility issues in this centre due to the preference of individuals and therefore in an effort to mitigate the issues which mainly arise about noise additional twilight hours are being provided to the residence until one resident has transitioned to an alternative centre.

• An electronic handover system is commencing, to allow for enhanced oversight by the PIC and PPIM.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• Staff will continue to seek opportunities for interaction and social engagement for people supported in the centre. Activities are being expanded to develop individualized activities for residents in line with their preference e.g. the use of an art therapist

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Since the time of this inspection works on the sensory room have been completed and all laundry equipment has been removed.
• The room is being utilized by residents for its intended purpose only

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The provider is committed to transitioning one resident to a more appropriate location in line with their assessed needs. Since the time of this inspection, there have been a number of steps taken to progress this and a transition plan will be developed to ensure that this occurs at a pace that is in line with the residents assessed need.

• As part of a roster review the 1:1 staffing hours have been adjusted for one individual who at times in the past has impacted on others due to loud vocalisations. Due to the changing needs of this individual and a significant reduction in incidents in which people have been impacted, the Provider is committed, in line with this individuals will and preference to continue to support this individual to reside at the centre.

• It is not currently possible to address all compatibility issues in this centre due to the preference of individuals and therefore in an effort to mitigate the issues which mainly arise about noise additional twilight staffing hours have been approved for the centre until one resident has transitioned to an alternative centre.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The staff roster has been adjusted to have three staff on duty up until 22.00hrs each night to support residents in regard to choices around access to evening activities and

choices around bed time routines. Additional twilight staffing hours have been approved for the centre until one resident has transitioned to an alternative centre.
• Residents rights is at the forefront of care delivery and the PIC is committed to this, a number of actions in this regard have been taken by the PIC to improve this such as:
o Roster reviews with times of staffing shifts adjusted
o Implementing activity schedules for residents and introducing new activities/opportunities for community engagement for residents
o The development of a sensory room for residents within the centre
o A review of the night time routines of residents and night shift planner
o A commitment to utilize regular agency staff where necessary who are familiar with residents care needs and can drive the company vehicles

• As part of a roster review the 1:1 staffing hours have been adjusted of for one individual who at times in the past has impacted on others due to loud vocalisations. Due to the changing needs of this individual and a significant reduction in incidents in which people have been impacted, the Provider is committed, in line with this individuals will and preference to continue to support this individual to reside at the centre.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	10/10/2023
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	31/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Not Compliant	Orange	31/12/2023

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	10/10/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	28/08/2023
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.	Not Compliant	Orange	01/12/2023
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in	Not Compliant	Orange	01/12/2023

	accordance with paragraph (1).			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	01/12/2023