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:	No.1 Stonecrop
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	02 November 2021
Centre ID:	OSV-0005120
Fieldwork ID:	MON-0033551

About the designated centre

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

The designated centre provides full-time residential supports for a maximum of five male adults aged over 18 years in County Cork. It provides support for persons with moderate to severe intellectual disability, including those with autism. The residents may have multiple/complex support needs and may require support with behaviours that challenge. The property is a large detached dormer bungalow which has been decorated with the full involvement of the people living in the house. The house includes six large bedrooms, a dining room, a kitchen, two sittings rooms, two bathrooms, one toilet and a garage. The centre is managed locally by a Social Care Leader supported by the person in charge. The core staffing is 2/3 staff on duty with one staff on sleepover duties and 1 staff night awake. Additional staff may be assigned to support particular activities during evenings and weekends, in line with priorities identified in individual resident plans.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 2 November 2021	08:50hrs to 16:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which was completed in No.1 Stonecrop to monitor compliance with the regulations. On arrival to the centre four of the residents were on the centre transport bus and were leaving to attend their individual day service. They were being supported by the staff team. One other resident was being supported by staff to get ready for their day. They were collected by their day service support staff.

The inspector took the time while the residents were in their day service to review the documentation and premises of the centre. During the pandemic the staff had assisted the residents in a number of activities in the garden area. A fence to the rear of the building had been painted by a local artist with a silhouette to represent each of the five residents. One showing a residents interest in planes and another in music. One resident had been supported to purchase an old boat. It had been sanded and painted with a table placed in the middle to allow for a seat and a cup of coffee.

The centre was currently being painted as this had been postponed due to the COVID 19 pandemic. The kitchen was also in need of repair and the person in charge reported that this was now at tender stage with a variety of prices being sourced. During the walk around it was noted by the inspector that one door upstairs was locked. When staff were questioned, the inspector was informed that this was locked for staff use only as the staff room allocated for sleepover was not en suite. This meant that the three residents whom resided upstairs had to use the downstairs bathroom both day and night, and that all five resident shared the one shower room. There was no evidence that this practice had been discussed with residents or that impact had been recognised. One resident had fallen coming down the stairs at night to use the toilet having to walk past the locked toilet.

The governance systems in place within the centre required review to ensure oversight was maintained and non-compliance's were identified and addressed in a timely manner. This included in such areas as restrictive practice. Whilst restrictions identified by the inspectors were in place predominantly to maintain the safety of residents these had not been identified as such by the provider with no assurance that these were utilised in the least restrictive manner in adherence with the regulations.Where the registered provider had completed the regulatory required monitoring systems these did not incorporate the views and opinions of the residents.

The inspector had the opportunity to meet with the five residents on their return to the centre in the afternoon. Residents greeted the inspector with an elbow rather than a handshake. One resident showed the inspector their bedroom and talked about their interest in rugby. They asked the staff what was for the dinner and told the inspector they could stay for dinner if they liked. The inspector thanked the resident but cordially declined. The resident was very comfortable in the presence of

the staff team and spoke of their day.

One resident on their return to the centre sat at the dining room table and had a cup of tea and a snack. They nodded hello to the inspector but chose not to interact further. This was respected by the inspector. Another resident was awaiting staff to draw a picture for them. They had used their I-pad to communicate to staff the plane they wanted them to replicate. Staff were attempting to replicate this for the resident who would then do one of their favourite activities and colour it in. The resident was waiting patiently in the living room for this.

Another resident met with the inspector in the hallway and brought them to their room to show them some of their favourite things. They had a keyboard in their room and they signed using their communication aid that they enjoyed music and art. They enjoyed jigsaws and staff had sourced jigsaws of the photographs of all the residents living in the house. The residents loved Halloween and some of this year's decorations were still evident in the garden. Throughout the centre photos were hanging of the residents and different activities they had enjoyed over the years.

The regulations reviewed as part of the inspection will be discussed in more detail throughout the remainder of the report.

Capacity and capability

The inspector completed the inspection of No.1 Stonecrop, to monitor compliance with the regulations. The judgements on this inspection established that the governance and management of this centre did not offer effective oversight to ensure that residents were safe and in receipt of a good quality of service and improvements were required to ensure that this oversight was consistently in place.

The registered provider had not appointed a clear governance structure to the designated centre. It was unclear on the day of inspection whom was the appointed sector manager for the centre both within documentation and with conversations with staff. Three differing individuals were presented as the sector manager, one of whom was recorded within the statement of purpose, another within a staff meeting and another verbally by the person in charge. One individual had been notified to the authority as a person participating in management in the role of sector manager. This required clarity to ensure all staff were aware of the governance structure in the centre. The person in charge was suitably qualified and experienced to be appointed to their role. However, within the organisation the person in charge held governance remit over a number of centres and concurrently did not have effective oversight within No.1 Stonecrop. The person in charge had delegated a number of responsibilities to the appointed social care leader, but measures were not in place for governance oversight of these duties such as supervision, team meetings and risk review.

The registered provider had ensured the completion of the regulatory required monitoring systems including the annual review of service provision and six monthly unannounced visits to the centre. Whilst a report had been completed following this where an action plan had been developed there was no record if actions had been completed as required. These reports had also not identified non-compliance's within the centre including the use of restrictive practices. Whilst restrictions identified by the inspectors were in place predominantly to maintain the safety of residents these had not been identified as such by the provider with no assurance that these were utilised in the least restrictive manner in adherence with the regulations. Also, these monitoring systems did not incorporate consultation with residents.

A system was in place within the centre for the review of incidents. Where one document requested a manager's signature to ensure oversight was in place this had not been signed in over 12 months by any member of the governance team. Where an incident form was completed by staff this was then forwarded to team leader and the person in charge for review. The date of this review was not clear and did not incorporate further actions required or actions implemented post an incident. For example, post an accident which resulted in a resident requiring medical review the following day, a governance review was not linked to the incident review and did not reflect a full review of causative factors leading to the accident.

A number of centre level monitoring systems were also in place within the centre and completed by the social care leader and staff team. This included regular fire safety checks and health and safety checks. The registered provider had ensured the skill mix and number of staff present in the centre was appropriate to the assessed needs of residents. Staff spoken were aware of the support needs of residents as set out in the personal plan. Staff were supported to raise concerns through team meetings which were completed by the social care leader and were not attended by another member of the governance team. Evidence of oversight of these meetings were not present. Staff spoken with stated the person in charge called to the centre once a fortnight.

Regulation 14: Persons in charge

Whilst the registered provider had appointed a suitably qualified and experienced person in charge to the centre, due to their governance oversight within the organisation they did not have effective governance systems in place.

Judgment: Substantially compliant

Regulation 15: Staffing

The staffing levels which had been appointed to the centre by the registered provider was appropriate to the assessed needs of the residents.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not appointed a clear governance structure to the designated centre. It was unclear on the day whom was the appointed area manager for the centre both within documentation and with conversations with staff.

Management systems in place in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Governance oversight following an accident was not clear.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had not ensured the development and review of the statement of purpose, incorporating the information required under Schedule 1.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured the notification of all notifiable events were notified in accordance with their regulatory responsibilities.

Judgment: Compliant

Quality and safety

The inspector reviewed the quality and safety of the service provided to individuals whilst residing in No.1 Stonecrop. Individuals were supported to engage in a range

of meaningful activities both within the centre and in the local community. However, actions was required to address a number of areas including resident's rights and infection prevention and control.

This inspection took place during the COVID 19 pandemic. All staff were observed to adhere to the current national guidance including the use of PPE equipment, and social distancing. An organisational contingency plan was in place to ensure all staff were aware of procedures to adhere in a suspected or confirmed case of COVID 19 for staff and residents. Residents were observed to be encouraged to wear face masks when out and about and to wash their hands on return to the centre. However, on the day of inspection it was noted that the kitchen area required cleaning for example, the cutlery drawer contained food residue, the utensils available for cleaning were dirty and the press under the sink required cleaning. Also, hand drying facilities within the bathroom areas was not readily available for visitors with no guidance on how to avail of this.

The premises was currently being painted and a new kitchen was at tender stage. During the pandemic residents and staff had completed a number of projects in the garden including planting and artwork. Internally the floor plans required review to accurately reflect the functions of all rooms. Residents were supported to decorate their bedrooms in accordance with their unique tastes and interests. The use of rooms in the centre required review to ensure that this was respectful of the residents rights and incorporated consultation with residents. For example, an upstairs bathroom was locked and identified solely for the use of the staff team present. This meant three residents whose bedrooms were upstairs, to use a downstairs bathroom both day and night. The rationale presented for this did not evidence that the residents were consulted in this practice or that the impact on residents was recognised. An accident had occurred in the centre as the resident had to use the stairs at night rather than the walking to the upstairs bathroom. The locking of the room had not been identified as a causative factor.

The registered provider had ensured that each resident was assisted to protect themselves from abuse. Where a safeguarding concern was identified, measures were implemented to protect the individual from all forms of abuse. There was clear evidence of ongoing review of any concern arising. The registered provider had also ensured that there was a risk management policy in place incorporating systems for the assessment, management and ongoing review of risk. Risk assessments had been completed and recently reviewed for the identified individual risks of residents and the general risk within the house.

The person in charge ensured that if required appropriate supports were in place to support and respond to behaviour that is challenging. Staff were observed supporting the residents in accordance with their individualised behaviour support plans and could articulate clearly the support needs of residents. The centre was presented to the inspector as a restrictive free environment. However, on observation it was noted that a number of practices which were restrictive in nature had not been identified and assessed as such. This including the locking of the front door at times and restricted access to all areas of the premises. This required

review.

The person in charge had ensured that each resident had a comprehensive personal plan in place. These plans incorporated a holistic approach to support needs and incorporated guidance from relevant members of the multi-disciplinary team. Monthly meetings were held with key workers to ensure that goals were progressing. Residents had recently returned to the day service and afforded amply opportunities for meaningful activities in the evening and at the weekends. Residents were consulted in their choice of activities and they would like to do. one resident had a keen interested in jigsaws, whilst another looked all things aviation.

The registered provider had ensured that each resident was supported to achieve and maintain the best possible emotional and physical health. They were supported by the staff team to attend appointments as required. Some improvement was required to ensure that guidance for staff was clear and reflected the current health diagnosis of the individual. For example, one resident had a support plan for asthma but had no formal diagnosis in place for same. Guidance for the use of as required medications also required review to ensure that staff were guided to use the correct medication for the correct condition. For example, one resident had guidance to use three different medications when displaying a cough.

Regulation 13: General welfare and development

The registered provider had ensured the provision of the following for residents:

(a) access to facilities for occupation and recreation;

(b) opportunities to participate in activities in accordance with their

interests, capacities and developmental needs;

(c) supports to develop and maintain personal relationships.

Judgment: Compliant

Regulation 17: Premises

The registered provider had not ensured that the layout of the centre was reflected in the floor plans. The use of rooms in the centre required review to ensure that this was respectful of the residents rights and incorporated consultation with residents

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider ensured that there was a risk management policy in place. Systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies required review. A risk register to address the environmental risk within the centre was present and reviewed by the appointed team leader.

Judgment: Compliant

Regulation 27: Protection against infection

Overall, the registered provider developed measures to ensure that residents who may be at risk from a health care associated infection were protected and that precautions and systems were in place in relation to the COVID-19 pandemic. An infection control audit and cleaning schedule were in place in the centre and staff had received relevant training in hand hygiene and infection control.

However, on the day of inspection it was noted that cleaning of the kitchen was not effective. Food residue was present in the cutlery drawer and on the dish clothes and brushes. Also, within the bathrooms hand drying facilities were not readily available for visitors.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety management systems are in place, this incorporated staff training, fire fighting equipment.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

All residents were supported to have an individualised plan in place which reflected there individual needs.

Judgment: Compliant

Regulation 6: Health care

The registered provider had ensured that residents were supported to achieve the best possible health. However, improvements were required to ensured guidance present in each personal plan was accurate and reflected the residents medical diagnosis.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge ensured that if required appropriate supports were in place to support and respond to behaviour that is challenging.

Where a restrictive practice was in use this had not always been identified as such within the centre, be it for the safety of the residents. For example, an upstairs bathroom door was locked which residents could not access and the front door was locked at times.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider ensured that each resident was assisted and supported to develop knowledge and self awareness required for keeping safe.

Judgment: Compliant

Regulation 9: Residents' rights

The use of rooms in the centre required review to ensure that this was respectful of the residents rights and incorporated consultation with residents. For example, an upstairs bathroom was locked and identified solely for the use of the staff team present. This meant three residents whose bedrooms were upstairs, to use a downstairs bathroom both day and night. The rationale presented for this did not evidence that the residents were consulted in this practice or that the impact on residents was recognised

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 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for No.1 Stonecrop OSV-0005120

Inspection ID: MON-0033551

Date of inspection: 02/11/2021

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The Provider is in the process of recruiting additional Persons in Charge in the Provider Governance and Management structure. This will reduce the number of Centre's assigned to the Person in Charge and will also facilitate the Person in Charge to work alongside the team to provide greater operational governance. [28/02/2022] Until such time as the revised structures are in place the Provider will ensure that the Person in Charge and the Team Leader are supported in meeting all regulations including implementing the identified areas requiring improvement such as training and staff development, records, premises, individualized assessment and personal plan and complaints.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure that the system of Governance and oversight includes the following key controls:- • The Person in Charge visits the Designated Centre at least once a week and is in daily contact via the phone and emails as necessary. • The Person in Charge receives a Weekly Service Area Report of all significant issues. • The Person in Charge meets with the Team Leader weekly • The Person in Charge has monthly Team Leader meetings, which in turn contributes to	

the agenda of the local staff meetings. The PIC will attend local staff meetings as necessary.
• The Person in Charge attends all Annual Multi D Reviews, Restrictive Practice Sanctioning Meetings and reviews.
• The Person in Charge has a Compliance Checklist that ensures monitoring of regulations.
• The Person in Charge has regular supervision meetings and contact with the Sector Manager.
The Provider has a management system in place to include the Person in Charge and Sector Manager.
• The Person in Charge attends monthly meetings with the Service Provider in relation to compliance with regulations.
• The Provider has a system of unannounced six-monthly visits and a schedule of audits to be carried out in the Designated Centre. These audits cover all Regulations. The Sector Manager and PIC discuss outcomes and action plans from these audits at regular meetings throughout the year to supplement the six monthly-visits.

The Provider has ensured that
- All actions arising from Provider visits to the Centre are follow up and a tracking system is in place for this purpose
- All incident forms are reviewed and follow on actions noted including identification of causation factors to inform risk management in the Centre.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Registered Provider has revised the floor plans in No.1 Stonecrop to reflect the change of the dining room to the staff office in the centre.
The statement of Purpose and Function was updated in 10 December 2021.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Register provider has amended the floor plans to reflect the correct lay out of the Centre.

The provider has ensured that all areas are accessible to residents in line with the Statement of Purpose. The PIC and the Social Care Leader, after consultation with the

Behaviour standards Committee, in order to safely keep the upstairs bathroom door unlocked, tap aerators have to be installed to reduce the flow of water in the taps, preventing flooding and over drinking. (8/12/2021). The Bathroom door is open for the use of everybody in the Centre. In addition a wireless floor sensor matt has been purchased, this is placed in front of the bathroom by day and the resident's bedroom by night. This notifies staff on duty that the bathroom door has been opened and at night it notifies staff that the resident is up so that they can safely support the resident. (29/11/2021)

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Provider has ensured that all cleaning schedules in the centre have been reviewed by the Person in Charge and Team Leader and they were further reviewed at a staff team meeting on the 24/11/21. The Cleaning schedule was updated to include a very clear list of duties to be performed in each area of the house.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Provider has ensured that the Person in Charge and Team Leader have reviewed all Persons Supported Health Care Management Plans to reflect appropriately medical diagnosis. 3/12/2021. The Services visiting Nurse Oversight Role will further review the residents Health Care Management Plans on the 11/01/2021

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Provider has ensured that the PIC and the Team Leader have reviewed all possible restriction in the Centre.

After consultation with the Behavior standards Committee, in order to safely keep the upstairs bathroom door unlocked, tap aerators have to be installed to reduce the flow of water in the taps, preventing flooding and over drinking. (8/12/2021). With the safety improvements the upstairs bathroom is now open for the use of everybody in the centre.

Again in consultation with the Behaviour Standards Committee, a wireless floor sensor matt has been purchased, this is placed in front of the bathroom by day and the resident's bedroom by night. This notifies staff on duty that the bathroom door has been opened and at night it notifies staff that the resident is up so that they can safely support the resident. (29/11/2021)

The traditional door lock of the front door has been replaced with a thumb turn lock which all residents will be able to operate and vacate the building safely of their own free will. (8/12/2021).

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Provider has ensured that the PIC and the Social Care Leader have consulted with the Behaviour Standards committee in relation to all possible restrictions in the Centre. Part of the procedures in reviewing restrictions includes consultation with residents. After consultation with the Behavior standards Committee, in order to safely keep the upstairs bathroom door unlocked, tap aerators have to be installed to reduce the flow of water in the taps, preventing flooding and over drinking. (8/12/2021). The Bathroom door is open for the use of everybody in the Centre. In addition a wireless floor sensor matt has been purchased, this is placed in front of the bathroom by day and the resident's bedroom by night. This notifies staff on duty that the bathroom door has been opened and at night it notifies staff that the resident is up so that they can safely support the resident. (29/11/2021)

Further to the above actions a referral has been made to the Rights Review Committee on behalf of the Persons Supported being monitored by a matt on their bedroom floor with a sensor that alerts staff when they leave their bedroom. (29/11/2021)

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	28/02/2022
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.	Substantially Compliant	Yellow	10/12/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out	Substantially Compliant	Yellow	10/12/2021

	in Schedule 6.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	10/12/2021
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 and effectively monitored.	Not Compliant	Orange	10/12/2021
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	10/12/2021
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality	Substantially Compliant	Yellow	10/12/2021

	and safety of the care and support provided to residents.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	24/11/2021
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	10/12/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	11/01/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental	Substantially Compliant	Yellow	08/12/2021

	restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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.	Substantially Compliant	Yellow	08/12/2021
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	08/12/2021