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:	Castlefield Group - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	05 December 2023
Centre ID:	OSV-0005237
Fieldwork ID:	MON-0035374

About the designated centre

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

Castlefield group is a community residential service providing adult residential accommodation for up to nine ladies and gentlemen with intellectual disabilities across two residential locations in West Co. Dublin. The houses are close to a variety of local amenities such as hairdressers, beauticians, pharmacy, shops, pubs, churches and parks. The first location currently provides accommodation for five ladies, and the second for four gentlemen. The first house house is a six bedroom semi-detached house in a cul-de-sac. There is a kitchen/dining room, sitting room, downstairs toilet and a main bathroom upstairs. The second location is a semi-detached house on a small cul-de-sac. It comprises of five single occupancy bedrooms one of which is used as a staff office and sleepover room. There is a kitchen/dining room, sitting room, downstairs toilet and a main bathroom upstairs. Residents are supported by a person in charge, social care workers and healthcare assistants, and staff support is available 24 hours a day, seven days a week. The staff team provides a variety of supports for residents who in some cases are of an aging profile.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 5 December 2023	09:40hrs to 16:50hrs	Marie Byrne	Lead
Tuesday 5 December 2023	09:40hrs to 16:50hrs	Erin Clarke	Support

What residents told us and what inspectors observed

This unannounced inspection was completed to follow up on the actions outlined by the provider in the compliance plan following a risk-based inspection in February 2023. In addition, the Chief Inspector of Social Services had been in receipt of unsolicited information since the last inspection relating to areas such as staffing and governance and management. Following receipt of this unsolicited information a provider assurance report was issued to the provider and their responses were used as lines of enquiry for this inspection.

Overall, the findings of this inspection were that a number of improvement had been made in the centre since the last inspection including filling staff vacancies, works to the premises, an increase in staff meetings, and improvements in relation to staff support and supervision. However, inspectors found that further improvements were required in areas such as staffing numbers and continuity of care, oversight and the completion of actions to bring about improvements, complaints management, the premises, risk management and medicines management. These areas will be discussed further later in the report.

Castlefield group provides 24-hour care and support for up to nine residents with an intellectual disability. Its consists of two houses within walking distance of each other in the west of Dublin. They were also close to public transport links, shops, restaurants and other public amenities. Since the last inspection the provider had changed the footprint of the designated centre by reducing the number of houses from three to two, and by reducing the number of registered beds from 13 to nine.

The inspectors of social services had an opportunity to meet with eight of the nine residents living in the centre during the inspection. One resident was at day services for the duration of the inspection. Inspectors had an opportunity to chat and spend time with residents throughout the inspection.

In the first house an inspector met with all four residents living in this house and one member of staff who was a social care worker. All residents greeted and communicated with the inspector at various stages during the inspection using their preferred communication method. On arrival at the centre, residents were getting ready for the morning, were in bed, or had already left the centre. There was an unrushed atmosphere, with residents having their own weekly schedule of activities, which included day programmes and paid employment.

This house is a semi-detached house with three resident bedrooms upstairs and one downstairs. There was a small combined kitchen and dining area and one sitting room. While there were limited communal areas, it was reported that residents got on well with one another, and there were no compatibility concerns at this time. As a result, residents appeared to enjoy spending time with one another and did not seek alternative areas in the centre to spend time apart. One area that the inspector noted that improvement could be made was the surfacing of the ground located

outside the house. Two cars could park in the drive, but part of the driveway was grassy, which resulted in muddy conditions that posed a health and safety risk. Other areas had been upgraded since the previous inspection, including the kitchen, which residents were involved in choosing the design.

The centre was decorated with a Christmas tree and other decorations that added to the homely feel of the centre. Residents spoke about their plans for Christmas Day, parties and shopping for presents. There was a warm atmosphere in the centre which felt very much like the residents' home. The staff member on duty knew each of the residents, their support needs, and communication preferences well.

One resident spoke to the inspector on their return to the house. The inspector spoke to the inspector about their employment, family and friends, girlfriend and also the improvements they would like to see in the house. The resident's bedroom was quite small, and they had made a complaint that they did not have enough space for their personal belongings. A shed had been installed in the back garden to provide more space for the resident. The resident showed the inspector their room, and there was limited space on either side of the bed, which they said made it difficult for them to get out of in the morning.

Another area of improvement identified by residents was to the centre's vehicle. The inspector was informed that the bus that they originally used was given to another house, and they were given a replacement vehicle, which was a large multi-seater vehicle that could allow a wheelchair onboard. At the time of the inspection, residents in this house did not require wheelchair support. The doors to the vehicle did not lock, and the servicing records of the vehicle were not kept in the centre or made available for review. The inspector also found that a resident's disability parking badge was no longer available to the resident as it left the centre when the previous vehicle went to a different centre.

The level of dependency that this centre could support was residents who required a low to moderate level of support. Some residents were very independent and, therefore, only needed minimal support from staff, while others required a higher level of support. The inspector found that the provider was reviewing residents' needs in terms of some emerging ageing healthcare needs in order to best support residents' assessed needs. This included occupational reviews for environment assessments and dementia testing.

During previous inspections inspectors learned that one resident had indicated that they wished to move from the designated centre to alternative accommodation. The human rights officer met with the resident, and a multidisciplinary team meeting was held to explore their wishes and preferences. The inspector found this was still an ongoing process as it was still to be determined what the resident's desire for a future home would look like.

In the second house inspectors had an opportunity to meet four of the five residents living there. This house is a six-bedroomed semi-detached house with four resident bedrooms upstairs and one downstairs. One bedroom was being used as a staff office. There is a large kitchen come dining room and two sitting rooms. There were

two residents at home on the morning of the inspection and three residents were in day services. On arrival, one inspector was greeted by a resident who was relaxing in the living room after their breakfast. They then went out to bring the bins back into the garden from the pathway outside the house as they just been collected. Later during the day this resident spoke with inspectors about their plans for the day, the important people in their life, holidays and events they had enjoyed during the year, and their plans for Christmas.

One resident was being supported by staff to get up and dressed when an inspector arrived. Their privacy and dignity was maintained by the staff supporting them and they appeared relaxed and comfortable when they came to the living area for breakfast. Throughout the morning they smiled and relaxed while watching what staff were doing in the kitchen. Staff were observed to maintain a low arousal approach to support them to remain relaxed and to make sure they were visible and available to them should they require any support.

One resident went to their bedroom on return from day services. They used their key to unlock their door and get their tablet computer to bring downstairs with them. On their way downstairs they chatted with both inspectors about their day and about the staff team. They spoke about who was on duty and who was due on duty. They appeared very comfortable moving around their home and were heard asking staff for support when they required it. One resident briefly said hello to inspectors when they got home from day services but chose not to engage further with the inspectors.

The provider were in the process of supporting one resident to move to another designated centre as a matter of priority once there was a vacancy. The required assessments had been completed and their planned transition was being kept under review and discussed at multidisciplinary meetings and at the provider's admission, discharge, and transfer committee meetings. There was an open complaint relating to the time it was taking to support this resident to move.

A number of residents had been supported by advocates and the provider's human rights officer and quality officer in relation to areas such as their wishes relating to accommodation, skills development, managing their finances and medicines. Residents' meetings were occurring regularly and agenda items included rights, safeguarding, complaints, advocacy, meal and activity planning, staffing and infection prevention and control (IPC). There was information available for residents in areas such as residents rights, IPC, fire, complaints, safeguarding, and the availability of independent advocacy services. A number of staff had completed human rights training and one staff spoke with inspectors about the impact of this training on their practice. They said that completing the training reminded them of the importance of person-centred and rights-based care. They spoke about residents' autonomy and the importance of them directing their care.

One resident had been supported by the new person in charge to create a video for "disability day" to show to show them independently going about their day and participating in their local community. The video showed them going for a pint, going out-and-about locally shopping, spending time with their friends, spending

time with animals, going bowling, and going swimming.

Inspectors found that residents in one house were supported by a staff team who were familiar with their care and support needs; however, in the other house this was not always the case and will be discussed further under Regulation 15. Inspectors met with three staff and the person in charge during the inspection and they were each found to be motivated to ensure residents were and felt safe in their home. Each of them were familiar with residents care and support need and their preferences in relation to how they liked to be supported. They were also very familiar with residents communication needs and preferences. Throughout the inspection, inspectors observed kind, caring and respectful interactions between residents and staff.

The input of residents and their representatives was being captured as part of the provider's annual and six monthly reviews. For example, the latest six monthly review by the provider included positive feedback from residents in relation to their home, their access to activities, and staff support. Resident surveys were not available at the time the annual review was completed; however, residents views were captured when the person completing the review visited the centre. Residents spoke to them about their involvement in the running of their home, in the decoration and upkeep of their home, and their satisfaction with how their home appeared. Residents' representatives were complimentary towards care and support in the centre in their satisfaction surveys. Examples of comments included in the surveys were, "totally satisfied with service provided", "always made feel welcome", and "I couldn't do any better myself.

In summary, for the most part residents indicated that they were happy with care and support in the centre. Some residents were voicing their dissatisfaction with aspects of their home and supports through the complaints process. They described meaningful opportunities to engage in activities they enjoyed. They were busy, and had things to look forward to. They were supported to stay in touch with the important people in their lives and to make choices and decisions about their day-to-day lives. There had been a number of improvements since the last inspection and areas where further improvements were required will be discussed further in the main body of the report.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

Overall the findings of the inspection were that a number of improvements had been made since the last inspection but the provider's systems for oversight and monitoring were not proving fully effective. This is reflected in the levels of compliance with the regulations reviewed during this inspection. While the provider

was bringing about improvements in a number of areas, they required more time to identify and implement a number of actions to move into compliance in areas such as staffing, governance and management, complaints management, the premises, risk management, and medicines management.

The provider's systems to monitor the quality of care and support for residents included six-monthly reviews and an annual review. These reviews were picking up on the majority of areas for improvement in line with the findings of this inspection. However, actions to bring about these improvements in some areas were not documented with corresponding timeframes. For example, actions relating to the review and follow up of medication related incidents.

A new person in charge had commenced in the centre in September 2023. Staff who spoke with inspectors were complimentary towards them and the support they provided. The person in charge was supported by a number of persons participating in the management of the designated centre (PPIM). They were also supported by a service manager and there was also an on-call nurse manager available to residents and staff on a 24/7 basis.

The staff team were working with each resident to develop their goals and develop and maintain their independence. Residents were complimentary towards the staff team and appeared comfortable and content in their presence. There were planned and actual rosters and they were well maintained. There were no staff vacancies in the centre and at the time of the inspection but the provider was in the process of completing a staffing review in line with residents' changing needs. Planned and unplanned leave was being covered by relief and agency staff and at times this was found to be impacting continuity of care and support for residents.

Staff had access to training and refresher training in line with the organisation's policy and residents' assessed needs. Some staff required refresher training and were booked onto these trainings. Staff were in receipt of regular formal supervision. A number of staff told inspectors they were well supported in their role, and aware of who to escalate any concerns they may have in relation to the quality and safety of care and support for residents. Staff meetings were occurring monthly and agenda were varied and resident-focused. Residents were protected by the provider's recruitment processes which included securing and maintaining the information required under Schedule 2 of the Regulations. Staff who required it has up-to-date registration with the relevant professional body and vetting disclosures were in place for staff in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Regulation 14: Persons in charge

The new person in charge had commenced in post in September 2023. They had the required qualifications, skills and experience. Residents and staff were very complimentary towards them and the support they provided them with. They were identifying areas where improvements were required and recording and tracking the

required actions. They were motivated to ensure that residents were happy, safe, aware of their rights and the complaints process, and engaging in activities and work they found meaningful.

Judgment: Compliant

Regulation 15: Staffing

There were no staffing vacancies at the time of the inspection; however, the provider was in the process of completing a staffing review in the centre due to residents' changing needs. It had been identified that staffing numbers needed to increase at key times during the day. The provider's human resources department had commissioned a member of the nurse practice development unit to commence the review. They had visited the centre just before the inspection to start the review.

There were planned and actual rosters in place and they were well maintained. Inspectors viewed a sample of rosters and found that continuity of care and support was very good in one house; however, in the other house there were a high volume of shifts being covered by different relief and agency staff which was impacting on continuity of care and support for residents. For example, over an eight week period 34 shifts were covered by relief or agency staff. Of these 34 shifts, 14 different relief or agency staff covered 15 shifts, and a regular agency staff who had worked in the centre for an extended period covered 19 shifts.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had completed mandatory training in line with the provider's policy and residents assessed needs. There were a small number of staff who required refresher training and they were booked onto these courses. A number of staff had completed human-rights training and more training in this area was planned.

Staff were in receipt of regular formal supervision to support them to be aware of their roles and professional responsibilities for the quality and safety of care and support for residents, and their role and responsibilities to raise and concerns about the quality of safety of care and support following the provider's policies and procedures. Staff meetings were occurring regularly, were resident-focused and staff had an opportunity to add to the agenda items.

Judgment: Compliant

Regulation 19: Directory of residents

There was a directory of residents in place. It contained the required information and was being reviewed and updated on an ongoing basis.

Judgment: Compliant

Regulation 23: Governance and management

The management structure was clearly defined and staff had clearly defined roles and responsibilities. The provider had systems for oversight and monitoring; however, these were not proving fully effective at the time of the inspection. For example, the annual and six monthly reviews were picking up on areas for improvement and identifying actions to bring about these improvements; however, some of these actions from previous inspections, audits and reviews by the provider were not bringing about the required improvements in areas such as complaints management, medicines management, and risk management.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record was maintained of incidents in the centre. Notifications of the occurrence of incidents set out under regulation 31 were provided to the Chief Inspector of Social Services within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy in place which was available in the centre in an easy-to-read format. Residents and their representatives had been made aware of and were using the complaints process.

The systems in place for recording and demonstrating oversight of complaints required review. While complaints were being logged and followed up on, in some instances it was not clear that the steps outlined in the provider's policy were being followed, or that complaints were being closed and resolved to the satisfaction of

the complainant.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policies required under Schedule 5 of the Regulations were in place and available to guide staff practice. They were being reviewed and updated at least once every three years.

Judgment: Compliant

Quality and safety

Overall, residents were in receipt of a good quality service; however, improvements were required in areas such as the premises, risk management and medicines management to ensure they were in receipt of a safe service. Residents were being supported to connect with their family and friends and to participate in their local community. Residents were choosing to go to work and day services regularly. They were being supported to develop and maintain their independence, make choices in relation to their day-to-day lives, and to be aware of their rights.

For the most part, the premises was designed and laid out to meet the number and needs of residents living in the centre. As previously mentioned a number of residents had voiced their dissatisfaction with some areas of their home. A number of works had been completed in the centre since the last inspection which had resulted in residents' homes appearing more homely and comfortable. Some areas where further maintenance and repairs were required and detailed under Regulation 17.

The provider had a risk management policy which contained the required information. There was a risk register and general and individual risk assessments; however, the risk register and some residents' risk assessments required review to ensure they were reflective of current risks and controls. In addition, the documentation in place did not demonstrate that the vehicles in the centre were roadworthy, regularly services, insured or equipped with the appropriate safety equipment.

The provider had a medication management policy to guide staff practice; however inspectors found that this was not being fully implemented at the time of the inspection. For example, a medication press was not locked for a period of time during the inspection, stocks of as required medicines were not in line with the maximum amounts stated in the provider's policy, and the review of documentation

relating to the administration of residents' medicines was not recorded in line with the provider's policy. There had been a number of medication related incidents in the centre and these required review to ensure the required control measures were implemented to reduce the risk of them re-occurring.

Regulation 17: Premises

A number of improvements had been made to the premises such as maintenance works, the renovation of two kitchens and the refurbishment of two ensuite bathrooms.

A number of areas where works were required relating to accessibility had just been identified in both premises in line with resident's changing needs and plans were in the early stages to complete these required works.

In line with the findings of the provider's latest six monthly review, inspectors found that re-grouting was required in a bathroom and some areas required paint touch ups. In addition there appeared to be a leak over a window in the upstairs hallway in one house and the paint appeared to be crumbling around the window. Inspectors were informed that this had been reported to the housing authority.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There was a risk management policy in place and a risk register and general and individual risk assessments had been completed. However, the risk register had not been reviewed since 2021 and some residents' individual risk assessments also required review as they were not reflective of the current risks or controls. For example, one resident had a risk assessment in place for staying at home independently and using an alarm but this was no longer active.

A different vehicle was available for use in one house and there was no documentation available in the centre for this bus, and the bus could not be locked. The vehicle checklist and information in the bus related to a different vehicle that was no longer being used for this centre. It contained information on the registration, insurance, annual service, NCT, equipment and fire extinguisher for a different vehicle.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medicines were not stored securely in one of the houses for a period of time during the inspection. In addition, on reviewing a sample of incident reports over a six month period inspectors found a number occasions where residents medicines had not been administered as prescribed. For example, there was an occasion where a resident received a double dose of a prescribed medicine, and an occasion where a resident received six doses of a medicines that was not prescribed to them over a three day period. In addition, there were a number of times when residents' prescribed medicines were omitted in error. Each incident had been reviewed and some additional controls had been put in place; however, trending, oversight and shared leaning from these incidents was not evident. The provider's latest six monthly mentioned the need for evidence of review by the person participating in the management of the designated centre of these incidents and a need to monitor and audit them to reduce the frequency; however there was no action or timeframe identified to complete these actions.

Stocks of as required medicines exceeded the maximum amount that should be stored in the centre which was stated in the provider's policy. While reviews of residents' prescribed medicines were being completed by a medical practitioner this was not reflected on residents medication administration records in line with the provider's policy.

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	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant

Compliance Plan for Castlefield Group - Community Residential Service OSV-0005237

Inspection ID: MON-0035374

Date of inspection: 05/12/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Nominee Provider has recruited for all vacancies within the centre, The PIC has identified regular relief and agency staff who can be scheduled on the roster for all planned absences. There is one SCW due to return to the centre from leave at the end of January 2024. The Provider will ensure additional resources are allocated to the centre in line with the review undertaken by the Nurse practice team.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PPIM and PIC will have regular scheduled meetings in 2024, a standing agenda item for these meetings is reviewing outcomes of audits and all incidents within the centre. The PPIM and PIC will identify time frames for actioning outcomes from 6 monthly provider visits.	
Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Provider has introduced a feedback form to the complaints procedure which the PIC will ensure is in place for all complaints this will ensure that the management of the complaint is reflected and the complainant is satisfied with the outcome.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Provider will meet with a representative of the Housing Authority to plan a schedule of works for all areas of work identified within the Centre.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Quality and Risk team will meet with the PIC and PPIM to undertake a comprehensive review of risk management within the centre. The PIC will review and update the risk register with the support of the PPIM to ensure all risks within the centre are accurately reflected. Paperwork associated with the vehicle in use within the centre is available within the centre. The resident who has a parking permit in his name has direct access to their permit.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The PIC and PPIM will meet with the community nurse team who provide training on medication management. They will identify areas for improvement based on a review of medication incidents with the PIC and arrange feedback to the staff team within the centre.	

Medication storage has been reviewed within the centre, excess medication has been returned to the pharmacy and the medication press has been relocated to a quieter area within the centre to ensure due diligence is given to medication management.
All medical personnel authorized to prescribe medications within the centre will be requested to accurately reflect the review of medication on the prescription document during upcoming reviews.

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.	Substantially Compliant	Yellow	28/02/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	28/02/2024
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/04/2024

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/04/2024
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	30/04/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2024
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	28/02/2024

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	28/02/2024
Regulation 26(3)	The registered provider shall ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.	Not Compliant	Orange	12/01/2024
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating	Not Compliant	Orange	31/03/2024

	to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 29(4)(b)	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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/03/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	28/02/2024
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints	Substantially Compliant	Yellow	28/02/2024

	including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			