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:	Stewarts Care Adult Services Designated Centre 26
Name of provider:	Stewarts Care DAC
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	29 October 2024
Centre ID:	OSV-0005839
Fieldwork ID:	MON-0043810

About the designated centre

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

Stewarts Care Adult Services Designated Centre 26 is a designated centre operated by Stewarts Care DAC. Designated Centre 26 comprises of three separate homes across three different locations in West Dublin. Residents are provided with long stay residential supports in community based settings. The centre is registered to accommodate up to seven residents and is staffed by a person in charge, nurses, social care staff and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 29 October 2024	09:30hrs to 16:30hrs	Karen McLaughlin	Lead
Tuesday 29 October 2024	09:30hrs to 16:30hrs	Michael Muldowney	Support

What residents told us and what inspectors observed

This report outlines the findings of an unannounced inspection of the designated centre. The inspection was carried out to assess compliance with the regulations.

Conversations with staff, observations of the quality of care, a walk-around of the premises and a review of documentation were used to inform judgments on the implementation of the national standards in this centre.

The designated centre is made up of three houses in three different locations in Co. Dublin. Inspectors visited all three houses throughout the course of the inspection.

On arrival at the first house, the inspectors were greeted by a staff member completing the night duty shift. Staff on duty made contact with the person in charge, who attended the centre later in the morning to support the inspection. This house was home to three residents, who were all getting ready to go about their day. Inspectors met all three residents. Two residents did not communicate their views with the inspector. One resident told inspectors that they were getting their hair cut and going out for coffee on the day of the inspection. They also told inspectors that they wanted to move out of the centre and to live on their own.

In the second house, one of the inspectors met the two residents who lived there. They did not verbally communicate with the inspector, but one resident shook the inspector's hand when they met the inspector. The residents were observed relaxing on the couch in the sitting room and using smart electronic devices. They appeared to be very relaxed and comfortable in their home.

In the third house, one of the inspectors met the resident who lived there, he showed the inspector around and told her that he was happy with the care and support he received.

Warm and kind interactions were observed between residents and staff throughout the inspection. Staff were observed to be very familiar with residents' communication preferences and to take the time to listen to and reassure residents when they needed them.

Staff spoken with across the three houses demonstrated a good understanding of the residents' care plans and associated interventions, including the measures to control risks to their safety. Furthermore, they told the inspector that residents were happy and safe in the centre and that the staffing resources were sufficient to meet residents' needs.

Overall, in each of the houses residents were observed receiving a good quality person-centred service that was meeting their needs. Residents were observed to have choice and control in their daily lives.

Across the homes in the designated centre, some residents enjoyed attending social clubs and community-based activities, while others preferred to spend more time at home. Some residents had recently enjoyed an overseas holiday with staff. Residents also enjoyed spending time with their families.

Inspectors saw that staff and resident communications were familiar and kind. Staff were observed to be responsive to residents' requests and assisted residents in a respectful manner.

In summary, inspectors found that aspects of the care and support provided to residents in the centre was effective and of a reasonably good quality. However, some improvements were required to ensure suitable arrangements were in place to meet residents' assessed needs at all times and to enhance the quality of care being provided.

This is discussed in the next two sections of the report which present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The provider had in place a clearly defined management structure which identified lines of authority and accountability. The staff team reported to the person in charge who in turn reported to a programme manager. Staff spoken with were informed of the management arrangements and of how to escalate issues or concerns to the provider level.

The provider was demonstrating they had the capacity and capability to provide a good quality service. There had been a number of governance and management improvements initiated by the provider since the previous inspection and these were found to be having a positive impact on the quality of service provided to residents.

The registered provider had agreed, signed contracts of care for each resident which outlined the terms by which each resident resides in the designated centre.

The person in charge maintained a planned and actual rota of staffing working in the centre. The maintenance of the rotas required improvement as they did not record the full names of all staff working additional hours clearly.

There was evidence that regular staff meetings were taking place. These provided staff with opportunities to raise concerns they may have about the quality and safety of the care and support provided to residents, as is required by the regulations. Topics referenced the centre's day-to-day management and the needs of residents and the staff team.

Regulation 15: Staffing

The staff skill-mix and complement comprised of one person in charge whole-time equivalent (WTE), 2.28 (WTE) social care workers and 20.82 (WTE) health care assistants across the designated centre, which the provider had determined was appropriate to the number and assessed needs of the residents. Additional staff resources were available to residents as they required, such as the provider's multidisciplinary team.

There were two permanent social care workers employed in the centre, with a whole-time equivalent vacancy of .28. The vacancy required review from the provider to ensure that the actual staff skill-mix was meeting residents' needs particularly since an additional premises had been recently added to the centre.

Inspectors viewed a sample of the recent planned and actual staff rotas in two houses. The rotas were maintained in electronic and paper formats. The organisation of the rotas required improvement to ensure that they could be easily cross referenced. Improvements were also required to ensure that the full names of staff working additional hours were clearly recorded.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were clearly defined management structures in place which identified the lines of authority and accountability within the centre.

There were effective arrangements to support, develop and manage staff, and for staff to raise concerns about the quality and safety of care provided to residents. Staff receive regular formal and informal supervision, and regular team meetings took place.

A series of audits were in place including monthly local audits and six-monthly unannounced visits. Audits carried out included infection prevention and control (IPC), fire safety, risk management, residents finance and activity activation. These audits identified any areas for service improvement and action plans were derived from these.

The provider had put arrangements in place to carry out an annual report of the quality of the service which had also sought feedback from residents and families as required by the regulations. Two residents provided feedback and said they were happy with the meals provided, with one resident saying they 'didnt want to live here.'

The provider was adequately resourced to deliver a residential service in line with the written statement of purpose. For example, there was an adequate premises, facilities and supplies and residents had access to two vehicles for transport.

For the most part, there were satisfactory governance and management systems in place in the centre that ensured the service provided was safe and effectively managed. However, some of the systems in place did not assure inspectors that there was appropriate oversight in relation to the care needs of the residents with improvements to the oversight of medication management and identifying restrictive practices required. This will be discussed further in the report under Regulation 29: Medicines and pharmaceutical services and Regulation 7: Positive behavioural support.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had provided each resident with a contract of care, which set out the terms by which each resident shall reside in the designated centre. Inspectors reviewed one of the contracts of care in the newest house within the designated centre and found it was signed by the resident and met the requirements of the regulation by clearly outlining details of the services being provided to support the resident's assessed needs.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of service for the residents who lived in the designated centre. Overall, inspectors found that the day-to-day practice within this centre ensured that residents were safe and were receiving a good quality and person-centred service.

Generally, each house was comfortable and well equipped and furnished with sufficient facilities and space. However two of the houses required maintenance work in areas such as flooring and painting of communal areas.

Inspectors found that the well-being and welfare of residents were actively promoted, and the provider and the staff team aimed to promote residents' rights and their personal development.

There were suitable care and support arrangements in place to meet residents' assessed needs. A number of residents files were reviewed and it was found that

comprehensive assessments of need and support plans were in place for these residents.

There were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. However, this inspection found some practices that had not been reviewed as potential restrictive practices. As a result inspectors could not be assured that there was adequate oversight of restrictive practices and that the least restrictive practice was in place for the shortest duration possible, this required improvement.

There was good record keeping at a local level regarding possessions and monies belonging to residents that were received or spent while in the centre.

Inspectors reviewed the safeguarding arrangements in place and found that residents were protected from the risk of abuse. Staff had received training in safeguarding adults. There were clear lines of reporting and any potential safeguarding risk was escalated and investigated in accordance with the provider's safeguarding policy. Potential safeguarding risks were reported to the relevant statutory agency.

The registered provider had prepared written policies and procedures outlining the practices for ordering, receipt, prescribing, storing, disposal, and administration of medicines. However, practices relating to the storage, receipt, and administration of medicines required enhanced oversight and consideration.

In summary, the inspector found that the residents enjoyed living in their respective homes and had a good rapport with staff. The residents' overall well-being and welfare was provided to a good standard.

Regulation 12: Personal possessions

Some residents required support to manage their finances while other residents were independent in this regard. An assessment of capacity to manage monies was carried out for one resident and guidance to support the resident to remain independent had been implemented alongside a personal safety plan.

The financial accounts of residents who received the provider's support with their financial affairs were well managed, and these were audited regularly to ensure measures were in place to safeguard residents' finances. All residents had a cash book that outlined all transactions, and these were checked daily by staff, and the person in charge signed off on them as being complete and accurate on a weekly basis.

A record of residents belongings and assets was reviewed in two of the houses and was deemed to be accurate and in order.

Judgment: Compliant

Regulation 17: Premises

The centre comprises of three separate houses within close proximity to each other. The houses were also close to a wide range of amenities and services including shops, cafés, and public transport links. Inspectors carried out a walk around of all three houses, and found that two of the properties required some upkeep and attention.

One house had been recently added to the footprint of the centre. It accommodated one resident at the time of the inspection, and was found to be appropriate to their needs and met the Schedule 6 requirements.

Another house was undergoing renovation and refurbishment. Since the previous inspection, there was new flooring in the communal areas, residents' bedrooms and the communal areas had been repainted, and the electrics and plumbing had been upgraded. The kitchen appliances had been replaced, and the sensory room had been upgraded with additional lighting. There was also a new garden patio, and inspectors observed a trampoline and seating furniture for residents to use. Additional works were to be carried out as part of the ongoing renovations. For example, the carpet on the stairs was heavily stained; and in one bedroom, the flooring was damaged, the ceiling was stained from a leak, and there was a large hole in the wall by the resident's bed.

In the other house, the carpet on the stairs and landing was heavily stained, the walls along the stairs required repainting, the kitchen and office floors were damaged, and the shower tray was dirty. Some of these matters had been noted in the provider's internal audits, however had not yet been addressed. One bedroom had been recently painted and furnished with special aids for the resident as recommended for their specific health care diagnosis.

Inspectors also found that mobility equipment, such as hoists and electric beds, were regularly serviced to ensure that they were kept in good working order.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The person in charge held responsibility for managing risks within the centre, and comprehensive risk assessments were in place for issues which had the potential to impact upon resident's individual safety or the overall delivery of care.

A risk management policy was in place which was up-to-date.

There was a centre specific risk register in place and associated risk assessments which had been risk rated and assessed.

Residents risk assessments were personalised to the need of each resident, including lines of support for staff when required.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had prepared written policies and procedures outlining the practices for ordering, receipt, prescribing, storing, disposal, and administration of medicines. However, inspectors found poor practices in the centre which were not in line with the policies, procedures, or good practice. This posed a potential risk to residents' health and wellbeing. Some of the poor practices had also been identified during the previous inspection of the centre in November 2023.

Inspectors viewed four residents' medicine administration record sheets and the associated documents including the protocols for administering PRN medicines (medicines as required) in two houses. They found the following poor practices (this list is not exhaustive):

- In one house, a locked medicines press contained two medicines that expired in April and July 2024 (the medicines were returned to the pharmacy on the day of the inspection). In the other house, a discontinued medicine was stored in a box with a resident's current medicines. Staff told inspectors that the medicine had been discontinued "a few months ago", however it had not been appropriately disposed of. This posed a risk that it may be used in error.
- PRN protocols were not in place for all PRNs as per the requirement of the provider's policy. The person in charge showed the inspector correspondence from the provider's nursing department which stated that protocols were not required for all medicines. However, this information did not align with the written policy.
- The directions on a prescription sheet for one PRN medicine were not clear regarding the frequency and length of time it should be used. This posed a risk of the medicine not being used correctly.
- One PRN medicinal product was prescribed for use twice per week. However, administration records noted that it was administered five times over a seven day period in October 2024. The consequence of this required assessment by the provider.
- Inspectors (with staff) counted a sample of residents' medicines, and found discrepancies in the amounts of three medicines. The discrepancies demonstrated poor auditing and oversight of medicine practices in the centre. The discrepancies require a review from the provider.

- One PRN medicine was not listed on the stock-take records. Furthermore, this medicine was not in stock in the house. This presented a risk that the resident may not receive this medicine promptly if they required it.
- Not all medicines were labelled which was a breach of the provider's policy.
- The dates of when certain medicines, such as creams, was to be recorded as per the manufacturer's information. However, inspectors found that two of these medicines did not have their opening dates recorded. This posed a risk that the medicines may not be as effective as they should be if administered.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors found that there was a system in place for assessing residents' needs and for ensuring that comprehensive care plans were in place to meet those needs.

Inspectors reviewed two residents' assessments of need and associated care plans. The assessments and plans viewed were found to be up to date and available to guide staff practice. There was evidence that care plans were created in a person-centred manner and included meaningful and individualised goals.

Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs, including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. Residents' goal setting was also an important aspect of the care delivered to these residents, with staff appointed with the responsibility for supporting residents to work towards achieving their chosen goals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Generally, there were appropriate supports in place for residents to manage their behaviours. However, some improvements were required, and the assessment of potential restrictive practices required more consideration from the provider.

Inspectors found that behaviour supports plans were in place for residents as they required them. The plans reflected input from relevant professionals, and staff spoken with were familiar with the contents of the plans. However, one plan dated August 2023 was due for review in August 2024. The person in charge told the inspector that the plan had been reviewed by the relevant professional, but that an updated version had not yet been provided. Inspectors found that some of the supporting documentation required more consolidation and better organisation. For

example, a protocol related to a specific behaviour, last reviewed in February 2021, was in the resident's active file. The person in charge told inspectors that the protocol was not longer in use. However, the protocol had not been removed which posed a risk of causing confusion for staff. The control measures to respond to a behaviour while travelling also required more detail.

There was a small number of restrictive practices, and the rationale for their use (for residents' safety) was clear. The practices had been approved for use by the provider's rights committee. However, inspectors found from conversations with staff that there were other potential restrictive practices in places, such as allocated seating arrangements while travelling. This matter required consideration from the provider, to ensure that any potential restrictions were identified and managed in line with the provider's policy.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were protected by the safeguarding policies, procedures and practices in the centre.

Staff had completed safeguarding and protection training and allegations and suspicions of abuse were reported and followed up on in line with the provider's and national policy. Safeguarding plans were developed and reviewed as required.

The provider had ensured effective systems were in place to guide and support staff on the timely identification, response, reporting and monitoring of any concerns relating to the safety and welfare of residents.

Safeguarding was discussed regularly at residents' meetings to increase residents' awareness and to support them in developing the skills needed for self-care and protection.

Staff spoken to knew who to contact in the event of a safeguarding incident and how it should be reported and recorded in line with national policy.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 26 OSV-0005839

Inspection ID: MON-0043810

Date of inspection: 29/10/2024

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: Based on review of the dependency needs assessments, the staff skill mix in the DC of Person in Charge 1 (WTE), 2 (WTE) social care workers and 20.82 (WTE) healthcare assistants is effectively meeting the diverse needs of residents, ensuring their safety, comfort and quality of life. This has been reflected on the statement of Purpose. The Person In Charge is committed to ongoing monitoring to ensure that the existing skill mix continues to match the residents' evolving needs. All planned and actual rosters are systematically saved electronically at the end of each week in Microsoft Teams. The importance of maintaining accurate and transparent staff records is acknowledged to ensure regulatory compliance and upholding the highest standards of accountability. Staff rosters are detailed with clearly recorded full names and shift patterns for additional hours worked. A system for weekly audits of rosters has been introduced starting from the 01/12/2024 to verify compliance and identify any discrepancies promptly.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Weekly medication audits are completed by staff, for professional oversight the Community Liaison Nurse is carrying out monthly medication audit review, their clinical expertise helps identify and mitigate risks promptly. In turn they will provide feedback and support to staff to improve medication management practices. The Person in Charge has completed a restrictive practice workshop which aimed at building staff's capacity for identifying and understanding restrictive practice both subtle	

and obvious and referral to the rights committee. The workshop also aimed at increasing awareness of legal frameworks, policies and ethical guidelines governing the use of restrictive practice.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The registered provider acknowledges the issues identified concerning premises and is committed to resolving these matters promptly and effectively. Ensuring a safe, hygienic and aesthetically pleasing environment is of paramount importance. A contractor has been engaged to repair damaged flooring, the hole in the wall will be professionally repaired and repainted and all carpeted area will be fitted with new carpets, this work is scheduled for completion by 31/03/2025.

Cleaning schedules have been reviewed and updated on the 01/11/24 to include regular cleaning of shower trays after use.

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 person In Charge will ensure all discontinued medications are immediately separated from active medications and returned to the pharmacy in a timely manner. A pharmacy returns book is used to record details of discontinued medicines and written confirmation of return from the pharmacy. Staff will receive periodic refresher courses on safe medication practices including handling discontinued medications and labelling date of opening of all medicines as per policy.

The Quality office will update the Safe Administration of medication management policy to align with the updated PRN protocol by 31/01/2025.
The Person In Charge and Community Liason Nurse reviewed all Kardex on the 10/11/2024 to ensure the direction and length of time for all PRN was clear.

PRN medications for all residents are listed on the stock take record and the missing PRN Movicol at the time of inspection was collected from the Pharmacy on the same day 29/10/2024.

The Person in Charge will ensure all medicines are labelled on receipt
From the Pharmacy and during weekly stock check. Periodic in-house training sessions will be conducted to reinforce knowledge and keep staff updated on best practice.

To ensure safe and effective medication practices within the DC, weekly medication audits have been reviewed and staff have been shown how to effectively complete same. The Programme Manager and/ the Community Liaison Nurse complete a monthly review of the audits and gaps discussed at morning handover and monthly team meetings to improve the overall residents' care quality.

Clear protocols are in place for when PRN medication should be used, and staff have been trained in the appropriate use of PRN medications. Regular audits are conducted to track usage patterns to monitor PRN medication administration to identify trends and potential overuse to ensure compliance with protocols and identify areas for improvement.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The Positive Behaviour Support Plan (PBSP) identified during inspection has been updated to include more detail on control measures to respond to behaviour of concern while travelling. The updated PBSP was attached to the service user record system Eclipse on the 18/11/2024 and is available to all staff to guide practice.

The Residents' active files have been reviewed and consolidated, discontinued protocols were removed and disposed in line with the Service user records keeping policy.

Regular tracking and monitoring of all incidents of potential restrictive intervention is maintained to ensure they are approved for use by the rights committee as per organisational policy.

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	31/12/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/12/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	31/03/2025

	kept in a good state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2024
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	31/12/2024
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	Not Compliant	Orange	31/12/2024

	ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	31/12/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their	Substantially Compliant	Yellow	31/03/2025

	behaviour.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	31/03/2025