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:	Dunshenny House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	15 & 16 May 2024
Centre ID:	OSV-0007987
Fieldwork ID:	MON-0043127

About the designated centre

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

Dunshenny House provides full-time residential care to adults with moderate to severe intellectual disability. The service comprises one building which is located close to a busy town. Residents are supported with co-existing conditions such as mental health illness and/or behaviours of concern, special communication needs, physical illness and conditions such as epilepsy and diabetes. Dunshenny House is accessible for people who are wheelchair users. Residents are supported by a qualified team of nurses and healthcare assistants who provide 24 hour care. Active night duty arrangements are in place.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 May 2024	13:45hrs to 18:30hrs	Úna McDermott	Lead
Thursday 16 May 2024	09:45hrs to 14:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This was an unannounced follow up inspection to an inspection that took place in February 2024. At that time, the inspector found non-compliance in four regulations and there were concerns in relation to the safety of the service provided. Further to this, a cautionary meeting was held with the provider during which the provider was put on notice of further actions that would be initiated should they fail to address the areas of non-compliance and areas of risk identified.

In response to the findings of the February 2024 inspection, the provider submitted a compliance plan which detailed the actions that they planned to take in order to bring the centre into compliance. The purpose of this inspection was to assess the provider's capacity and capability to complete the actions required, to sustain their response and to return to compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013).

On this inspection, the inspector found the provider had taken some action in order to improve in the quality and safety of the service provided which will be expanded on in this report. However, ongoing work was required to strengthen the leadership arrangements in the centre and to improve the governance and management systems used in order to continue to return to full compliance.

Dunshenny House is located in a rural area on the outskirts of a busy town. There were three residents living there at the time of this inspection. Two residents lived in the main house and one resident lived in an annex to the main building. Each resident had their own bedroom and bathroom facilities. In the main house, there was a combined kitchen and dining room which was well equipped to meet with the residents needs. The sitting room was bright and nicely decorated. One resident lived in the annex. This resident had significant behaviours of concern and the inspector found that the provider has put suitable living arrangements for this person in place. They had a nice home which met with their assessed needs.

This inspection was completed in two parts, one afternoon and the following morning. On arrival, the inspector met with a nurse in charge who told the inspector that they were employed by an agency and that it was their second day on duty. When requested, they made contact with the person in charge and the provider representative. Another nurse arrived a short time later and they explained that they were allocated responsibility to facilitate the first part of the inspection. This person was described as a 'bank nurse' and they were employed to provide support in areas of the service when required. They had a good knowledge of the service and of it recent regulatory history. The person in charge and the registered provider representative facilitated the inspection on the second day.

The inspector met with all three residents during the course of the two days. On the first afternoon, the resident that lived in the annex had left the centre to attend a medical appointment. They were supported by a core staff nurse that knew them

well. This nurse made arrangements to attend the centre in addition to their normal working hours, in order to support the resident as consistency of care and support was required. The appointment was reported to go well.

This resident was observed during both parts of the inspection. On the first day they were relaxing in a comfortable chair in their sitting room. On the second day, they presented as anxious asking for items in their home such as the bin, be repositioned. The inspector could see that the staff on duty were competent and patient with the resident. However, the staff were observed as busy, as they were meeting the needs of the resident while working to maintain a low arousal environment. They were doing this effectively at the time of inspection.

Two other residents were observed in their sitting room of the main house. They were completing activities and having tea at the table, listening to music and planning outdoor activities as the weather was pleasant. One resident presented as anxious and was moving from place to place while vocalising. However, this did not impact on the atmosphere, which was pleasant and relaxed. Staff interactions with the residents were calm, kind and supportive and requests were attended to promptly. Later that evening, a home cooked meal was prepared. The inspector observed the resident enjoying their meal in the early evening, which suited their needs that day. This was found to be similar to what may happen in a typical home environment.

Over the two days, the inspector spoke with the person in charge, the provider representative and eight staff members. When asked, staff spoke about training in human rights. They told the inspectors that access to online training was provided and that they found it interesting and supportive. They spoke about the principles of human rights, the importance of consent and ensuring privacy and dignity was supported. For example, staff said that residents had a right to stay in bed longer if they wished to do so, as it was their home. While being aware of other residents, they also spoke about a resident's right to express their feelings loudly if they wished to do so, as this appeared to help them feel better.

All staff members spoke about gradual improvements in the centre since the last inspection. They said that although a high number of behaviour support incidents continued to occur in the centre, the resident at risk was provided with consistency of care and support. This was an improvement since the last inspection. However, they said that not all consistent agency staff were trained at the time of inspection. This was observed by the inspector, who noted that the agency staff nurse on duty on the afternoon of the inspection was new to the service and therefore they did not work in the annex. In addition, staff spoke about continuing changes in the leadership of the centre. The current person in charge commenced in March 2024. They held other roles of responsibility with the provider and although reported to be readily available by telephone or short visits, they were not an active presence in the centre. This will be expanded on further below.

From discussions with staff members and observations made, the inspector found that while there were gradual improvements in the service, more work was required to build upon what was achieved. In particular, the governance arrangements in the

centre required review to ensure that staff were supported by a consistent leadership presence in the centre and that there was effective oversight of the quality of the documents held at the centre.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service provided.

Capacity and capability

The provider had a governance structure in place and staff were aware of their responsibilities and who they were accountable to. However and as outlined, ongoing changes in the leadership arrangements at the centre impacted on the oversight of the service. The inspector found that the nursing team were highly motivated and working hard to support the role of the person in charge. However, as they were busy with their substantive front line roles, their efforts were not always effective. As outlined some improvements were evident, however, these needed to be sustained and built upon through a consistent leadership arrangement. In particular, the oversight of positive behaviour support and safeguarding and protection required reviewed. In addition, ongoing attention to staffing, staff training, and risk management were required in order to comply with the regulations.

The inspector reviewed the planned and actual rota and found that the service continued to be heavily reliant on agency staff in order to run the service. In the main, this was well managed with consistent agency staff members but it was not sustainable. In addition, there were improvements in the provision of nursing care since the last inspection. However, work was required to ensure that the rota was in line with requirements and that it provided a clear and accurate reflection of the staff employed to support the service.

As part of this inspection, the inspector reviewed the arrangements that the provider had in place to ensure that appropriate mandatory and refresher training was provided for the core and agency staff members. The inspector found that training for the core staff members was up to date. This was an improvements since the last inspection. However, not all agency staff had mandatory training completed and a record of their training needs was not readily available in the centre.

The person in charge appointed had oversight of more than one designated centre and they had additional responsibilities with the provider. This meant that although they were readily available by telephone and through visits to the centre, they were not consistently present. As this centre had experienced seven changes of person in charge in a 14 month period, the leadership arrangement required extra effort to ensure that it was embedded in the centre. A review of the requirements of regulation 23 found that the centre was well resourced and the service provided was person centred. However, additional oversight of the documentation systems and

processes was required.

The next section of this report will describe the care and support that people receive and if it was of good quality and ensured that people were safe.

Regulation 14: Persons in charge

The provider appointed a person in charge for the centre, however, they had oversight of more than one designated centre and they had additional responsibilities with the provider. The following required review;

- Although they were readily available by telephone and through visits to the centre, they were not consistently present. As this centre had experienced seven changes of person in charge in a 14 month period, this required review.

Judgment: Substantially compliant

Regulation 15: Staffing

As part of this inspection, the inspector reviewed a sample rota for the period 21/04/2024 to 16/05/2024. There were clear improvements in staffing arrangements since the February 2024 inspection. For example;

- Although heavily reliant on agency staff to support the delivery of the service, in the main, they were regularly employed in the service and this meant that there were improvements in consistency of care and support.
- There were improvements in the arrangements in place to ensure that nursing staff were available to support the assessed needs of the residents.

However, ongoing work was required. For example;

- To ensure that agency staff members are used as part of a contingency plan only and that a full complement of trained core staff members are employed in the service.
- To ensure that the name of the person in charge is documented on the staff rota and that their availability to the service is clearly identified in order to accurately reflect all staff on duty.
- To ensure that changes to the rota are documented correctly at the time of the change occurring in order to accurately reflect the staff on duty.

Judgment: Substantially compliant

Regulation 16: Training and staff development

As part of this inspection, the inspector reviewed the arrangements that the provider had in place to ensure that appropriate mandatory and refresher training was provided for the core and agency staff members. This included a review of the training matrix on 15/05/2024. There were improvements since the February 2024 inspection. For example;

- Mandatory training for the core staff team was up to date and staff spoken with demonstrated knowledge and competence in relation to the areas of operational risk in the centre.

However, ongoing work was required. For example;

- The inspector reviewed the number of agency staff employed during a four week period prior to the date of inspection (14/05/2024 to 12/05/2024). Six agency staff were employed during this time most of whom were consistent staff members. However, they were not included on the provider's training matrix and their training records were not readily available for review in the centre. Due to the complex needs of the service and the requirement for training prior to working with particular resident, this arrangement required review.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that this designated centre was well resourced and the service provided was person-centred and in line with the statement of purpose. As previously outlined there were improvements found since the February 2024 inspection. For example,

- Improvements in the provision of nursing staff and consistency of care and support.

However, there were ongoing changes in the leadership and management of the service and a reliance on agency staff to support the operation of the service. This impacted on the quality of the governance and management systems in the centre. Although improvements were found since the February inspection, this needs to be built upon further through improved governance arrangement. For example;

- A new person in charge/clinical nurse manager 2 was appointed on 15/03/2024, but was not regularly present at the centre.
- Although the provider had plans to employ a clinical nurse manager 1 to support the role of the person in charge, this was not in place at the time of

inspection

- There was an over reliance on the centre's nursing team to support and complete governance tasks such as staff allocation and staff replacement.
- A team meeting had not occurred in the centre since 19/12/2023.
- The audit systems did not consistently identifying gaps in the service and ensure actions were effectively documented and addressed promptly.
- An additional audit completed by a clinical nurse manager 3 (16/10/2023) identified improvements in relation to the availability of accident/incident records in the centre. The actions documented were not effective, as a significant discrepancy remained between the number of accidents/incidents recorded on the incident log (127) and the actual records available for review in the centre (45) for the sample period.

Judgment: Not compliant

Quality and safety

The residents living in this centre were supported by a dedicated staff team. They had active lives in their community and were supported to spend time with their families. They had a person-centred plans in place and a range of goals agreed which were in line with their individual preferences. All staff spoken with were highly motivated, keen to provide a good service and to support the resident's needs. However, improvements in governance and management systems were required in order to support the staff team and to sustain the quality and safety of the service provided.

The resident living in the annex had access to a behaviour support specialist and their positive behaviour support plan was available for review. The system in place to update this when new behaviours occurred required review. As outlined, not all staff were trained in positive behaviour support.

The provider had arrangements in place to ensure that residents were protected from abuse. The layout of the centre ensured that residents lived in appropriate living spaces and this reduced the possible impact on behaviours of concern on the wellbeing of others. However, the oversight of safeguarding and protection training and documentation systems required review to ensure that clear guidance was provided for staff.

The provider had some systems in place for the assessment and management of risk. However, ongoing work on the documentation systems was required to ensure that assessment were subject to regular review and that controls measures were updated.

In summary, the residents living at this centre had a range of high support needs and were at risk of significant behaviours of concern. They were supported by a

dedicated front line staff team. Although consistency of care and support was provided, there was a heavy reliance on agency staff to support the running of the service. In addition, ongoing changes in the leadership of the service impacted on its oversight. While improvement were found since the last inspection, further work was required in order to return to compliance. This was dependent on a clear and consistency leadership presence in the centre.

Regulation 26: Risk management procedures

The provider had some systems in place for the assessment and management of risk, which included risk management policies, a service level risk register and individual risk assessments. However, the inspector found that;

- Not all risks were reviewed and updated by the person in charge promptly. For example, the risk assessment relating to opening of the car door (27/02/2024) was reviewed and updated on the second day of inspection (16/05/2024).
- Not all risk control measures were clearly identified. For example, a risk assessment in relation to removal of clothing was completed on 08/04/2024. While staff spoken with knew what to do if this behaviour occurred, these practical measures were not documented on as control measures on the risk assessment.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A resident living at this designated centre required support with complex and high risk behaviours of concern. Access to behaviour support specialists was provided and their behaviour support plan was reviewed on 16/02/2024 and available to guide staff in the centre. However, due to the resident's complexities, 127 incidents occurred between 01/02/2024 and 15/05/2024 most of which were attributed to behaviours of concern. While the staff team along with multi-disciplinary supports were working hard to support the resident, the arrangements were not effective. For example;

- Not all agency staff members had training in positive behaviour support. A sample of six agency staff reviewed, found that four required training.
- This meant that support with behaviours of concerns was provided by the same core staff team who were at risk due to the intensity of their input into this part of the service. This required review.
- The resident had some behaviours that were new and not documented on their behaviour support plan. These included the removal of clothing at home

and in the community (08/04/24) and the opening of vehicle door while moving (27/02/24). Their behaviour support plan and assessment of need required updating to ensure that all behaviours were documented and assessed in line with the provider's policies.

Judgment: Not compliant

Regulation 8: Protection

Although the provider had some arrangements in place to protect resident from abuse, they required review to ensure that they were effective. For example;

- While all core staff had training in safeguarding of vulnerable adults, information on agency staff training in safeguarding and protection was not readily available in the centre.
- A resident subjected to a safeguarding incident on 04/06/2023 had a safeguarding plan in place. Following the February inspection, their intimate care plan was comprehensively updated by their named nurse (27/03/2024). However, evidence that it was reviewed by the person in charge was not provided as the signature line was blank.
- In addition, safeguarding guidelines were not consistent across all relevant documents and this was not identified. For example, a nursing intervention referring to intimate care (17/04/2024) did not refer to the specific guidance relating to safeguarding risks as outlined in the intimate care plan referred to above.
- Furthermore, a preliminary screening form had the name of another resident not residing at the centre, on all pages apart from page one. This was brought to the provider's attention previously by the HSE Safeguarding and Protection Team (06/06/2023) and by the Authority (20/03/2024).

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Dunshenny House OSV-0007987

Inspection ID: MON-0043127

Date of inspection: 15/05/2024 & 16/05/2024

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: To ensure compliance with Regulation 14: Persons in Charge, the following action is being undertaken • The process of recruitment for a PIC for Dunshenny House is ongoing through the HR department. The position has been advertised and the closing date for applications has been extended to 19-06-2024 to provide the best opportunity to fill this position. Completion date: 30-09-2024 pending derogation.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15: Staffing, the following actions have been/will be undertaken • The name of the PIC has been included on the centre's roster to reflect their working hours in the centre. Completion date: 12-06-2024. • The actual roster will be reviewed on a daily basis to ensure that it is accurate and correct and reflects the staff complement on duty. • The process of recruitment for a PIC for Dunshenny House is ongoing through the HR department. The position has been advertised and the closing date for applications has been extended to 19-06-2024 to provide the best opportunity to fill this position.	

Completion date: 30-09-2024 pending derogation.

• Where staff vacancies arise in the centre the PIC will ensure these vacancies are filled with consistent agency staff in so far as is reasonably possible.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
To ensure compliance with Regulation 16: Training and Staff Development, the following actions will be undertaken

• The PIC will complete a training needs analysis for each agency staff to establish training requirements. Completion date: 12-07-2024

• The PIC is in the process of developing a training matrix for the centre to capture and monitor the mandatory and site specific training completed by all agency staff. Completion date: 12-07-2024

• The PIC will monitor the training matrix on a fortnightly basis to ensure all training in completed within the agreed timeframe.

• The PIC has scheduled training for agency staff on Positive Behaviour Support on the following dates, 8th & 9th July and the 15th & 16th July 2024. Completion date: 31-07-2024.

• The PIC will ensure that consistent agency staff complete all mandatory and site specific training within the agreed timeframes. Completion date: 30-08-2024

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance with Regulation 23: Governance and management, the following actions have been/will be undertaken

• The PIC has developed a schedule for local governance meetings for the remainder of 2024. Completion date: 20-06-2024

• The most recent local governance meeting took place on the 12-06-2024. The minutes from this meeting are available in the centre and have been brought to the attention of all staff for review.

• The process of recruitment for a PIC for Dunshenny House is ongoing through the HR department. The position has been advertised and the closing date for applications has been extended to 19-06-2024 to provide the best opportunity to fill this position. Completion date: 30-09-2024 pending derogation.

• The Cavan, Donegal, Leitrim, Monaghan, Sligo HSE Disability Services Annual Schedule of Audit has been implemented within the centre and all audits to date have been reviewed by senior management. The PIC will ensure that all audits are completed in line with the schedule and that audit is a standing agenda item at centre governance meetings.

• The PIC will ensure that all actions arising from audits are added to the centres QIP, timelined and closed out as per timeline agreed.

• A review of the process of accident/incident record management has been undertaken by the PIC. A defined process has now been implemented to ensure that accident/incident logs match the actual number of accident/incident forms on site. This process was communicated to all staff at the local governance meeting held on the 12-06-2024 and documented in the minutes of the meeting.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure compliance with Regulation 26: Risk Management Procedures, the following action will be undertaken

• The PIC will review and update all risk assessments to ensure all adequate controls are in place to mitigate risk identified. Completion date: 12-07-2024

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To ensure compliance with Regulation 7: Positive behavioural support, the following actions have been/will be undertaken.

• The PIC has updated the Positive Behaviour Support plan to reflect the new behaviors displayed by one resident. Completion date: 20-06-2024

• The PIC has scheduled a meeting with the psychologist to review the additional information as part of the overall positive behavior support plan. Completion date: 12-07-2024

• The staff team has been updated regarding the new behaviors relating to one resident at a local governance meeting on the 12-06-2024. Completion date: 12-06-2024.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance with Regulation 8: Protection, the following actions have been/or will be undertaken.

• The PIC is in the process of developing a training matrix for the centre to capture the mandatory and site specific training required to be completed by all agency staff. Completion date: 12-07-2024.

• The PIC has reviewed the Intimate Care Plan for one resident to ensure the plan contains all necessary information to meet the needs of the resident. Completion date: 20-06-2024.

• The PIC has also reviewed the nursing intervention for the resident to ensure the intervention includes specific guidance in relation to safeguarding risks for the resident. Completion date: 20-06-2024.

• The named nurses will complete a full review of all resident documentation to ensure all information is documented on the most up to date relevant templates to include a review of all preliminary screening forms. Completion date: 12-07-2024.

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	30/09/2024
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	Substantially Compliant	Yellow	30/09/2024

	than full-time basis.			
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	12/06/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/08/2024
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	30/09/2024
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	Substantially Compliant	Yellow	12/07/2024

	system for responding to emergencies.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	31/07/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	12/07/2024