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:	Ballynakelly
Name of provider:	Cheeverstown House CLG
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	05 June 2024
Centre ID:	OSV-0008691
Fieldwork ID:	MON-0042324

About the designated centre

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

Ballynakelly is a designated centre registered to provide community-based residential care and support service on a full-time basis for up to three adults with an intellectual disability, mental health diagnosis or other assessed health and social care needs. This centre is a detached bungalow in a suburban residential area in Co. Dublin, in which each resident has a single bedroom and shared use of a communal living room, kitchen and dining room, garden spaces, accessible bathroom facilities and accessible vehicle. The support team consists of social care workers, with nursing and clinical support available as required.

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 5 June 2024	09:20hrs to 18:00hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with all three residents in the designated centre and observe how they spent their day, as well as speak with their direct support staff and review documentary evidence of their support plans, as part of the evidence indicating their experiences living in Ballynakelly.

This designated centre was opened to accommodate three residents who had previous lived on a large congregated campus setting, as part of this provider's long-term project to ultimately transition people off the campus site to smaller community settings, in line with "Time to Move On from Congregated Settings: A Strategy for Community Inclusion" (Health Service Executive, 2011). Residents moved together with their staff support, and the inspector observed evidence to indicate that residents and families had been facilitated to see the house in advance and being consulted on the move, to be assured that the location, premises and resident combination was safe and suitable in providing a positive living environment.

As this inspection was announced in advance, residents were advised what would be happening and were introduced to the inspector. Family members advocating for the residents were also notified of the inspection, and had communicated their experiences with the service through questionnaires which were provided for review. The residents in this centre had specific support needs and did not communicate using speech. The inspector observed front-line staff communicating with them in a patient and encouraging manner which was suitable for their communication profile. Residents appeared overall happy and comfortable with their support team. One resident went swimming during the day, and another resident was using a computer tablet to listen to their music. One resident spent time sitting out in the garden space, and the inspector observed staff ensuring they were adequately protected from the sun. Staff described examples of new opportunities enjoyed by residents since the move, such as following matches of the football season of a local club, watching horses or going to races. Residents enjoyed going to a local pub, to a swimming pool, the barber and the supermarket.

The staff spoken with during the day demonstrated a good knowledge of the personalities and characters of the residents, as well as what they enjoyed doing in the houses and community. From speaking to staff and reviewing documentary evidence the inspector observed that the transition had had its challenges, but was overall successful for all three residents, who had settled into their new home. The inspector also observed that some more institutional practices had been changed since moving off the campus. For example, doors were not alarmed in this house, and the provider was in the process of attaining access to personal accounts with financial institutions in residents' names, to retire the need to make requests for residents' personal money from a finance office on the main campus.

The inspector observed evidence to indicate how residents' health, social and

personal care and support needs were affected by issues regarding centre resources, which will be described later in this report. The inspector found that the regular staff team were endeavouring to make best use of days on which a full team worked in the centre to get residents into the community and progress their personal development and life enhancement opportunities. Similarly, staff were identifying challenges arising due to shifts which were not fully staffed, or staffed with personnel less familiar with residents' needs, including delays in achieving objectives, or community recreation which could not be attended. As one resident required the support of two staff when outside of the house and none of the resident could safely be left home alone, community access was limited when only two staff were on duty.

The next two sections of the report 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.

Capacity and capability

This was the first inspection of this designated centre for the purpose of monitoring the provider's regulatory compliance since the service was registered in December 2023. In the main, the inspector found this to be a service which was resourced with a knowledgeable and supportive staff team, but was not adequately resourced to ensure optimal continuity of support for the residents and staff team during absences and vacancies. The inspector observed evidence to indicate incidents, adverse events and practices arising in the first six months of operation for which there was limited evidence of escalation.

The inspector observed that residents and their representatives had been involved and consulted in the transition from a campus bungalow to this suburban community home for an extended period of time prior to the move, to be assured that residents were supported to understand and be comfortable with the change. This was greatly aided by staff members and the person in charge coming with the residents to their new home, and overall the team had had success in this undertaking and the inspector observed examples of positive outcomes for the residents in their new home and local area.

Due to staff vacancies, inconsistent staff allocation, staff who could not be rostered together, and staff on long term absence, the person in charge and main support team had experienced challenges in ensuring that shifts were reliably filled and continuity of care was maintained. Evidence was not available on the day of the inspection to provide assurances that some personnel working on the team had the requisite training to support the residents assessed needs, such as responding to communication, epilepsy, dysphagia and mobility support needs.

From a review of residents' signed contracts and available records of resident

expenses, the inspector observed that all three residents had been paying for pharmacy related charges for which the provider was liable for as per their signed contracts. The provider committed to resolving this issue as soon as possible.

There was limited evidence to indicate how supervision and reporting structures were used to ensure that, where incidents had occurred or challenges had arisen for the local management and staff team, these were brought to the attention of the service provider for action in a timely manner. Some instances were observed of where actions or risk analysis, identified as required following accidents and incidents in the centre, had not occurred.

Regulation 15: Staffing

The inspector observed evidence during this inspection which indicated that the staffing levels and skill mix were not sufficient to meet the assessed needs of residents, and how this was negatively affecting the ability of the staff to effectively carry out their support delivery, for the manager to have sufficient protected time to supervise the team, and for the residents to have continuity in their care and support.

This centre was assessed as requiring three staff support during the day and one waking night shift to meet the residents' assessed needs. The inspector reviewed nine weeks of worked rosters for this designated centre which indicated a frequent use of staff from a relief panel or from other designated centres. In addition to this, 20% of the dates reviewed also utilised a number of personnel deployed from an agency. Despite these contingency arrangements, the inspector found that approximately 67% of day shifts were staffed by the required three personnel.

While half of those days were when the person in charge was on-duty, it was not clear from these rosters when that person was based in this designated centre or another centre, for which they were person in charge until shortly before this inspection. Shift leads on days the manager was absent were not clearly denoted. Rosters were also not complete, with some rosters recording that one or no staff worked in the centre at times, with the staff later confirming that further agency shifts were worked but were not recorded. Where agency shifts were recorded on the roster, they were listed without names.

Evidence observed during this inspection indicated that this lack of continuity of familiar staff support had impacted on quality of support delivery. Staff spoke on behalf of themselves and the residents, noting that activities or community access would be postponed due to lack of adequate numbers or staff who could drive, how care delivery would not be as timely, and how non-familiar staff would not have the same knowledge of residents' routine, preferences or communication styles, increasing the demand on the rest of the team.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had a policy on the supervision and oversight of staff working in this designated centre. This identified that the staff would have a formal supervision meeting with their line manager twice a year or as required, in addition to a performance development session annually. Staff performance development sessions had been held for staff which set out goals related to their competencies for the year ahead, and these goals were in the main appropriate and individualised. However, the inspector observed that none of the staff working in the house had had one-to-one supervision meetings, including staff who were facing challenges in their workplace and staff who were to be met following certain events in the centre.

The provider had conducted a training needs analysis of what skills and formal training were required by the staff allocated to this designated centre. Staff contracted to work in this centre were up to date in mandatory training such as fire safety and safe administration of medicines. However, the person in charge had no means of being assured that staff deployed from the relief panel or other centres, including those who worked alone in the centre or had been allocated on an ongoing basis, were suitably trained in requisite skills. The inspector observed training completed by staff and found gaps in training identified as mandatory or relevant to the assessed needs of residents. This included training in supporting people with autism, epilepsy, or dysphagia (difficulties in swallowing), or who required support in assisted decision making.

Judgment: Not compliant

Regulation 23: Governance and management

As referred under Regulation 15 on staffing, the designated centre was not resourced with sufficient relief and contingency staffing personnel to consistently provide effective support to residents based on their assessed needs, and to ensure that shifts were filled routinely, during times of absences of the main team. The person in charge and the front-line staff advised the inspector on what they were doing to work around staffing limitations on a day-to-day basis including the effects of long-standing vacancies, long-term absences, frequent use of contingency measures, and staff members who could not be allocated to work the same shifts. In the main, the knowledge and quality of support of the person in charge and front line team had ensured that these limitations did not result in risk to the health and wellbeing of the residents.

The inspector found limited evidence of how these issues were being addressed by senior management, with no reference to these matters in recent governance

meeting records, and actions and control measures taken by the provider to mitigate the potential effects on the local management, contracted staff team and residents' support. Following this inspection, the provider provided written assurance that these matters had been identified and were being managed at a senior provider level to support this designated centre.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had a written contract which they, or their representative, had signed in agreement with the registered provider, outlining the terms and conditions related to their residency in this designated centre. While these contracts had been revised following the move to a new service, some references to their old home remained.

The contracts agreed and signed between the service provider and the residents stated that the provider would pay for any prescribed medicines which were not covered by the residents' medical cards, as well as pharmacy charges. The inspector observed evidence that these payments were being made using the residents' personal money.

At the end of this inspection, a member of the provider's senior management committed to ensuring that all three residents would be reimbursed their money in the coming days and would not be charged for these expenses going forward.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place for this designated centre, which contained information required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was an experienced clinical nurse manager employed full-time with this provider. They held a qualification in management and were knowledgeable of their role and responsibilities under the regulations.

Judgment: Compliant

Regulation 19: Directory of residents

The provider had collated a directory of the residents' information required under this regulation.

Judgment: Compliant

Regulation 22: Insurance

The provider supplied evidence of appropriate insurance in place against risks in the centre, including injury to residents.

Judgment: Compliant

Quality and safety

The inspector was provided examples from the manager and staff team of how they were endeavouring to overcome previously mentioned resource challenges, to progress residents' support to the best of their ability. Staff advocated for the residents in highlighting when objectives were delayed, and took advantage of the availability of sufficient staff and drivers to get residents active and engaged in their new community.

Residents were supported to participate in enjoyable activities such as going to see horses or football games, going swimming, getting to know the neighbours and local amenities, and accompanying staff grocery shopping. The inspector observed that residents now had financial accounts in their own names, and would not be required to request their own money from a "patient private funds" account in the provider's head office. While this was a work in progress, the work represented significant progress compared to practices and access in the residents' previous setting.

Staff demonstrated competency in how to administer, record, store, refrigerate, and dispose of residents' medicines, including medicine requiring nurse administration, or for specific criteria to be met first.

The premises was clean, suitably accessible and equipped to detect, contain and alert staff to fire and smoke. Some development was required in the provider's methodology for practice evacuation drills to be assured that all staff who worked

alone at night would consistently follow the correct procedure and for the provider to be assured on how much longer an evacuation would take at night, with factors such as lone-working staff and residents requiring support.

The provider had revised residents' assessment of needs, and amended care and support plans where necessary, to reflect their new living environment and local resources. Plans were overall detailed and person-centred, with staff filling monitoring charts were required. Plans had suitable guidance provided by allied health professionals to ensure that support with eating, drinking and using of residents' mobility devices was done safely and with regard to each person's needs.

Regulation 11: Visits

There were no restrictions in place to limit visitors from coming to this house. The inspector observed evidence to indicate that visitors were made feel welcome, and that residents could receive them in an appropriate communal living room.

Judgment: Compliant

Regulation 13: General welfare and development

The inspector observed evidence that residents had had a positive experience transitioning to a new house and community. The local management and staff team demonstrated examples of how they had supported residents to move away from routines associated with living in a congregated setting. For example, attending pubs and restaurants in the area, doing grocery shopping, attending football matches and enjoying other new or different social and recreational opportunities in the community. Similarly, staff had made note of where personal objectives had not been successful, and highlighted where recreational or community engagement was called off due to insufficient resources or other factors, for learning going forward. The inspector observed evidence to indicate how the provider had made sure to address any concerns or anxiety of the residents and their representatives both before and after the transition into this community setting.

Judgment: Compliant

Regulation 17: Premises

The premises of the designated centre was suitably designed and laid out for the number and assessed needs of residents. The house was equipped with adequate space and accessible features to support residents with needs related to their

mobility. The house had suitable kitchen, bathroom and garden spaces, and private bedrooms which had adequate personal storage space and were appropriately decorated. The premises was in a good state of maintenance and was clean, bright and well-ventilated.

Judgment: Compliant

Regulation 18: Food and nutrition

All residents' FEDS (feeding, eating drinking and swallowing) assessments had been reviewed since moving to their new home. The speech and language therapist had composed meal-time instructions to ensure food and drinks were served in safe manner, including for residents requiring modified diets or who were at risk of choking.

The house was stocked with sufficient quantities of food, drinks, snacks, treats, and where required, supplements and drink thickeners.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider maintained a register for this designated centre of risk identification and analysis which had taken place on matters related to this designated centre, its resources and its residents. However there were some gaps in assessments and risk rating identified as an action following adverse accidents and incidents, and assessments to identify, rate and mitigate risks related to the impact of the centre's current resources on the delivery of care as referred elsewhere in this report. Following this inspection, the provider confirmed that some risk matters have been identified and were being managed at provider level.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The premises of this centre was suitably equipped with fire safety features to effectively contain, detect and alert staff to fire or smoke in the house. The house had multiple, clearly marked final exits and evacuation routes, and internal evacuation pathways were protected with doors which were suitably fire rated and equipped with smoke seals. Staff were up to date on their fire safety training, and

carried out routine checks of evacuation routines and alarms. Equipment such as fire extinguishers and emergency lighting were up to date in their service and certification.

The provider had conducted practice evacuation drills to ensure that staff and residents could safely and promptly exit in an emergency, with drills conducted during the day achieving safe exit times. For a night-time scenario in which staffing would be at a minimum, the provider had conducted a simulated fire drill with one staff member, which consisted of them verbally describing how they would carry out an emergency evacuation during a night shift. This had not been done with any other staff who routinely worked night shifts, so that the provider could be assured of how long it would take a lone-working staff member to follow emergency response procedure and support all residents to evacuate. In speaking to staff members and reviewing documentation, the inspector observed some discrepancy in evacuation processes, such as the order in which to evacuate residents requiring assistance, and whether residents who were supported first were safe to be left alone after exit.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had carried out assessments of capacity to determine the appropriate level of support for residents in the management and administration of their prescribed medicines. Staff demonstrated a good knowledge of the purpose and administration requirements for medicines, including for medicines prescribed only for use when certain criteria are met. For injected drugs, facilities to dispose of sharp clinical waste was provided and was secure. Some medicines required administration by a nurse only, or required refrigeration, and this was followed in practice.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of support needs had been conducted for each resident following their transition into a new designated centre, which ensured that the information was up to date and reflected changing circumstances. The inspector reviewed a sample of these, and found that where residents had been assessed as requiring support plans, these were developed with input from relevant members of the multi-disciplinary team and included notes related to changes in monitoring charts, prescriptions and staff interventions. These plans were overall written in a person-centred and respectful manner to each individual on supports including

activities of daily living, communication, positive behaviour support, and support with moving and transferring.

Judgment: Compliant

Regulation 6: Health care

Staff members were provided guidance in relation to the healthcare support needs of residents, and were keeping general observation records where required. Records were kept of healthcare appointments, hospital reviews and vaccination against illnesses. In the sample of healthcare plans reviewed, the inspector observed a resident whose healthcare support and risk controls required annual review by a specialist doctor, who had not been seen or referred to them since 2021.

Judgment: Substantially compliant

Regulation 8: Protection

Staff had been trained in identifying and responding to suspected or alleged instances of abuse. Concerns had been reported regarding allegations of inappropriate staff engagement with residents which were subject to investigation by the service provider and advised to the Health Service Executive safeguarding and protection team for their review.

For residents requiring personal assistance with dressing, hygiene and using the bathroom, staff were provided appropriate and tailored intimate care plans to safeguard residents' dignity and bodily integrity. Where residents had money in the house, the staff had oversight measures to account for how and when it was received and spent. The person in charge provided evidence that oversight of bank accounts was a work in progress and was awaiting structures and oversight measures to be authorised.

Judgment: Compliant

Regulation 10: Communication

The inspector reviewed a sample of support plans related to communicating with residents whose primary means of communication did not involve speech. The inspector found person-centred communication strategies methods to guide staff, with evidence to indicate that these had been recently updated by the speech and

language therapist.
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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 10: Communication	Compliant

Compliance Plan for Ballynakelly OSV-0008691

Inspection ID: MON-0042324

Date of inspection: 05/06/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC and the PPIM will conduct a review of the staffing for this centre and any vacancies will be recruited against. The organisation has arranged a Recruitment Day on the 19/06/24 in one of the local Hotels to actively promote recruitment within the service. The Person In Charge is solely responsible for this Designated Centre and has no other centre of responsibilities. A new rostering system has commenced within the organisation and is in its infancy. Some features are been further configured with the software developers to ensure that it can reflect all rostering needs. An interim plan consisting of the PIC printing out rosters on a weekly basis will be put in place to ensure that team leads and agency staff will be named.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff within the centre and any support staff who support this centre will have specific training completed in line with the training needs analysis of the Centre based on the resident's needs. A schedule of supervisions was devised between the PIC and staff and these will be	

completed for all staff within the centre.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC and the PPIM will conduct a review of the staffing for this centre and any vacancies will be recruited against. This review will include a review of staffing skill mix to maximize staffing resources for this centre.

The organisation has arranged a Recruitment Day on the 19/06/24 in one of the local Hotels to actively promote recruitment within the service.

The Person In Charge is solely responsible for this Designated Centre and has no other centre of responsibilities.

A local risk register is in place for this centre and a new tab will now be reflected under the Environment and Health & Safety risk assessment to capture the impact of the current resources on the delivery of care.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
All payments made for prescribed medication and medication related charges have been reimbursed to the residents.

An appendix will be added to each residents contracts of care which will clearly outline all charges and fees payable by the resident.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A corporate risk assessment was completed in Nov 2023 for the organisation in relation to the HSE recruitment pause and the impact on service user's experience and business continuity. Lack of essential resources impacts quality of care delivery and the organization's ability to achieve positive outcomes for the people we support. This risk assessment remains open and is risk rated as high. Each Designated centre has a contingency plan in place to identify the safe staffing supports for the centre and supports in terms of staffing resources and how to respond to same. A local risk register is in place for this centre and a new tab will now be reflected under the Environment and Health & Safety risk assessment to capture the impact of the current resources on the delivery of care. The PIC will review and update the resident falls predication score (Falls Risk Assessment) and implement any actions in line with our falls management standard operation procedure to ensure that learning occurs from adverse accidents and incidents.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire Drills have commenced and a scheduled has been devised for staff who routinely worked night shifts, so that the provider can be assured of how long it would take a lone-working staff member to follow emergency response procedure and support all residents to evacuate. All Individuals PEEPS to be reviewed and updated to reflect safe evacuation process for all residents in the event of the fire.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: A gap identified in a residents healthcare annual review in realtion to a specialist consultant was noted by the inspector. This resident was referred by their GP on the 30/01/24 and was referred to the specialist consultant. A phone consult was held on the 04/24 and a full review was carried out with no changes to current plan of care. A copy	

of this report has been requested for the residents file and to be reflected in the residents personal plan.

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.	Not Compliant	Orange	31/08/2024
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.	Not Compliant	Orange	31/08/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	31/10/2024

	showing staff on duty during the day and night and that it is properly maintained.			
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.	Not Compliant	Orange	30/09/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2024
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.	Substantially Compliant	Yellow	31/07/2024
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate,	Substantially Compliant	Yellow	30/07/2024

	the fees to be charged.			
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.	Substantially Compliant	Yellow	30/06/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/08/2024
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	21/06/2024