Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Park View
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	16 August 2019
Centre ID:	OSV-0005828
Fieldwork ID:	MON-0027353

About the designated centre

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

Park View is a residential service located in Co. Kilkenny close to a range of local amenities. The service currently provides supports to two individuals with an intellectual disability, with an application in progress to increase the footprint and capacity of the centre to afford supports to a further two residents, over the age of eighteen years. The service operates on a 24 hour, 7 day a week, basis ensuring residents are supported by staff members at all times, with effective governance systems in place. As set out by the provider, Park View "aims to develop services that are individualised, rights based and empowering, that are person centred, flexible and accountable". The accommodation currently consists of one two bedroom apartment within a two storey house, comprising of living room, kitchen and bathroom. Within the application the centre will increase to include the upstairs two bedroom apartment

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 - 2015 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
16 August 2019	09:30hrs to 16:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the two individuals currently residing within the centre throughout the day. On arrival, one resident was being supported by staff to commence their day. Staff members were observed communicating with the resident in their unique manner and ensuring eye contact was maintained. Staff were regularly observed showing this resident objects, to ensure that they were aware of what they were going to do next. For example when the residents were going for a spin in the car, car keys were shown. The resident spent periods of time sitting on their favourite chair in the living room, playing with their favourite object that produced a rattle and sensory toys, vocalising to staff when they wanted a new one. Staff were keenly aware of vocalisations and their meanings. The resident went for a walk with a staff member around the estate whilst waiting for their peer to wake before heading out and about.

Another resident was having a lie in on the day of inspection and staff were seen to support them on waking, in a respectful and dignified manner. Staff spoke of the resident participating in a wide range of activities which had increased immensely since transitioning to their new home in December 2018. The resident was observed smiling and interacting positively with staff when brought for a walk and smiling in the car.

Overall, residents were observed to be very well cared for in the centre and provided with a good quality of life since their transition to the community. Staff were very knowledgeable to the support needs of the residents.

Capacity and capability

The inspector reviewed the capacity and capability of the registered provider to provide a safe effective service to the residents currently residing within the centre. The registered provider had submitted a complete application to the authority to increase the footprint of the centre, to facilitate supports to be afforded to a further two residents by incorporating an upstairs apartment. Whilst a clear governance structure was in place with clear lines of responsibility and accountability there was uncertainty regarding the current board of management following notification of cessation of operation of the board from the 1st December 2019.

The registered provider had appointed a person in charge to the centre. This person was suitable qualified and possessed the necessary experience to fulfil their governance role within the centre. They possessed a clear understanding of their regulatory requirements. They had a positive working relationship with the staff team and reported directly to the person participating in management of the

centre. Whilst a board of management was in place within the organisation and actively engaging in the operation of the centre and organisation, notification had been received by the authority of their withdrawal by the end of 2019.

The registered provider had effective systems in place for the implementation of an annual review of service provision by a delegated person. This review was comprehensive in nature and utilised to identify areas for improvement. A robust time bound action plan had been developed with on going review of actions by person in charge and person participating in management. However, an unannounced visit had yet been completed since the centre became operational. At centre level an organisational monitoring and audit schedule had been developed to ensure the ongoing promotion of improvement of service provision. Whilst a number of these audits had been completed such as fire safety, health and safety audits were not consistently implemented in line with this schedule. Where implemented, audits were utilised to monitor service provision and to ensure a safe service.

Staffing arrangements currently in place required review to ensure appropriate numbers were in place at all times to meet the assessed holistic needs of residents. Whilst one resident required two to one support for certain activities such as personal care and manual handling this required the second staff member to be available to afford these supports. This in turn, resulted in an impact in the choice of activities and locations of the second resident. Staff spoken with were knowledgeable to the support needs of the residents and the needs of the service.

The person in charge had measures in place for the ongoing supervision of staff. Staff spoke that whilst formal quality conversations are productive the person in charge is readily available for discussions and they are confident all concerns raised would be addressed in a timely professional manner. Staff were encouraged to participate in monthly staff meetings, where they were also supported to discuss any issues. Incorporated into quality conversations were the training needs of staff. Some improvement was required to ensure that all staff were supported to access appropriate training including refresher training. Staff whose training needs had been identified had training booked in the coming week.

There were no complaints currently active within the centre. Staff spoken with could clearly articulate the complaints procedure and whom to report a complaint to. The complaints officer details were visible at the entrance to the centre. Whilst an organisational policy had been developed, conflicting versions were available within the centre with it unclear to which version was the most up to date version.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted a full and accurate application to increase the footprint of the centre including the relevant fees.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a person in charge to the centre. This person was suitable qualified and possessed the necessary experience to fulfil their governance role within the centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing arrangements currently in place required review to ensure appropriate numbers were in place at all times to meet the assessed holistic needs of residents.

An actual and planned was in a place and reviewed as required.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had measures in place for the ongoing appropriate supervision of staff. Some improvement was required to ensure that all staff were supported to access appropriate training including refresher training.

Judgment: Substantially compliant

Regulation 19: Directory of residents

Whilst a directory of residents had been developed for the centre, improvements were required to ensure the information present was accurate and up to date.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider has ensured the centre was appropriately insured.

Judgment: Compliant

Regulation 23: Governance and management

A clear governance structure had been appointed to the centre, however notification had received by the authority of the withdrawal of the board of management of the organisation by the end of 2019.

The registered provider had effective systems in place for the implementation of a comprehensive annual review of service provision, however, an unannounced visit had yet been completed since the centre became operational. At centre level whilst a number of monitoring systems were in place there was non adherence to the developed organisational audit schedule.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose had been developed for the centre. The version available on-site did not reflect the current application to vary the registration of the centre. The correct document had been forward to the authority as part of application process.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all notifable event were submitted to the authority in accordance with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

Whilst an effective complaints procedure was in place within the centre clarification

was required with regard to the version history of the organisational complaints policy to ensure were consistently provided with most up to date information.

Judgment: Substantially compliant

Quality and safety

The inspector reviewed the quality and safety of the service provided to the residents currently residing within Park View and found that since the residents transition to their new home their quality of life had improved. There was evidence of increased community activation and participation in social roles. Residents engaged in activities within the home at an increased level and were consulted in the day to day operations of the centre. Staff were observed utilising a range of communication methods through the day to ensure communication was promoted as an effective two way process. 'Talking tiles' were in place to ensure one resident was aware of their surroundings. These tiles when pushed by resident or staff produced sounds associated with the rooms. For example the front room was indicated by the six o clock news theme music. Objects were utilised to promote communication for another resident. Communication needs of each resident were clearly laid out with their personal plan.

The centre was currently operational as one downstairs, two bedroom apartment. This environment was homely and welcoming with tasteful decoration throughout. Each resident had a private bedroom which with support from staff had been decorated in accordance with their interests and family connections. An upstairs apartment was currently in the decorating stages with two bedrooms to be decorated by the intended residents as part of their transitional programme. The area presented as spacious and homey with the facility of two living areas. The rooms to the rear of the upstairs area required review to ensure the privacy of residents was maintained as it looked directly into neighbouring houses.

A transitional plan was in the early stages of development for the intended residents pending the outcome of the application process. This plan included time frames from receipt of registration to the moving in of the residents, incorporating such activities as individualised plans, social stories and risk assessments. This plan incorporated ongoing consultation with residents and their representatives.

The person in charge had ensured that each resident had an individualised personal plan in place. These plans required review to ensure the changes for residents over the past twelve months were highlighted. For example, visioning meetings had not been reviewed since the residents transition to the community, where they now availed of a varied range of actives, differing from their previous residence. Whilst a plethora of guidance was available to guide staff on support needs, due to the amount of information held, this at times could be difficult to find. For example, whilst residents were supported to achieve the best possible health information,

relating to supports required, they were located in a number of areas within the plan. Where goals had been developed, evidence of progression was minimal with no account made of non-progression such as ill health.

Staff supported and facilitated residents to participate in a range of meaningful activities. Staff could clearly speak of the resident's interests and favourite activities such as a country drive, however this was not evident within the personal plan. Staff had supported residents to engage in new activities since their transition and continued to discover new activities. For example, one resident now enjoyed going to the zoo and the aquarium. Residents were observed to be happy when activities were occurring within the house. If they chose to, residents could attend a day service in the local area.

The registered provider had effective measures in place to ensure the residents were protected from abuse. Through the development of an organisational safeguarding policy and staff training, staff were provided with effective procedures and processes should a concern arise. To further enhance a safe environment the registered provider had ensured effective measures were in place for the detection, containment and extinguishing of fires. Through regular fire evacuation drills residents and staff were supported to become familiar with evacuation scenarios which may occur.

The current arrangements in place to ensure the identification, assessment, management and review of risk required attention to ensure their effectiveness. Whilst effective measures were in place relating to individual risks for residents, a number of environmental risks had not been identified or addressed within the risk register. For example, presence of oxygen and manual handling. Where risks had been identified a risk assessment had been completed, incorporating current control measures in place to reduce the impact and likelihood of the risk . Corresponding standard operating procedures were in place to ensure staff were guided on procedures to adhere to should a risk arise.

Regulation 10: Communication

The registered provider had ensured that each resident was assisted and supported at all times to communicate in accordance with the residents' needs and wishes.

Judgment: Compliant

Regulation 13: General welfare and development

Staff supported and facilitated residents to participate in a range of meaningful

activities. Residents had been supported to participate in range of new activities since their transition to their new home. If they chose residents could attend a day service in the local area.

Judgment: Compliant

Regulation 17: Premises

The premises presented as a warm homely tastefully decorated environment. Each resident had a private bedroom which with support from staff had been decorated in accordance with their interests and family connections. The rooms to the rear of the upstairs area required review to ensure the privacy of residents was maintained as it looked directly into neighbouring houses

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

A transitional plan was in the early stages of development for the intended residents pending the outcome of the application process. This plan incorporated the holistic needs of the intended services users and the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The current arrangements in place to ensure the identification, assessment, management and review of risk required attention to ensure their effectiveness and to ensure al risk were identified and addressed.

An organisational policy was in place including the regulatory required information.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had ensured effective fire safety systems were in place within the centre. These incorporated regular fire safety checks of all fire fighting

equipment and regular evacuation drills consisting of a number of scenarios.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Whilst the person in charge had ensured the development of a comprehensive personal plan for each resident, these required review to ensure all information present was clear and reflective of the resident's current needs.

Where goals had been developed there was limited evidence of progression of goals.

Judgment: Not compliant

Regulation 6: Health care

The residents were supported to achieve the best possible physical and mental health.

Judgment: Compliant

Regulation 8: Protection

The registered provider had ensured effective measures were in place to protect all residents from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had ensured the centre was operated in a manner which was respectful of the residents. Residents were consulted in the day to day operations of the centre.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Park View OSV-0005828

Inspection ID: MON-0027353

Date of inspection: 16/08/2019

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: Parkview has adequate staffing levels and the right skill mix to support the people living in the designated centre. The PIC is reviewing the rosters on an ongoing basis. This will ensure flexible and forward planning of activities for all people supported based on their individual choices and holistic needs. A flexible roster is in place to ensure appropriate numbers of staff are assigned to support the people's choices in meaningful day activities.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All employees are supported to attend mandatory and mandated training. It is also the responsibility of employees to propose training that would enhance and support their role within St. Patrick's Centre (Kilkenny). A centre specific training profile, individual employee training profiles and a training schedule are distributed monthly to the PIC and CSM of the centre by the Training Department. Employee training is on the agenda of the monthly team meetings and also discussed individually through Quality Conversations. Training Update:	

• All employees have completed Manual & Patient Handling Training by 21/08/2019.
• Three employees are attending Studio 3 training from the 9th – 11th September 2019.
• All employees have completed Fire Training 1 by 03/09/2019
• All employees will have completed Fire Training 2 by 11/10/2019.
• One employee is booked for medication administration refresher training on the 25/09/2019.

There is a Quality Conversations policy in place. The policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for employees. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

The PIC has scheduled 6 weekly Quality Conversations with the staff team.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
The Directory of Residents was updated by the PIC and Quality Department on the 27/08/2019. The PIC ensured that the updated version is now available in Parkview in the house folder system.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Governance:

SPC BOM intends withdrawing from the future governance of service provision (to include Parkview) and therefore, in addition to submission by SPC, of NF35's to the regulator, SPC BOM intends issuing the HSE with formal written three (3) month's-notice, of its termination of the Agreement between it and the HSE, to expire on December 31st, 2019.

SPC hopes that if the HSE delivers on the identified outstanding issues, this Notice can then be withdrawn.

The BOM and SPC executive will work collaboratively with the HSE and all other stakeholders in the intervening period to ensure as seamless a transition as possible.

The Board acknowledges and respects the recent notification by HIQA, of its proposed decision to refuse the application for registration of Parkview and this decision is under appeal.

Meetings and Quality Conversations:

A clear governance structure is in place within the designated centre. The PIC is supported by a Community Service Manager through monthly Quality Conversations with SMART action plans.

The PIC is supporting the staff team through monthly team meetings with a standard agenda and individual 6 weekly Quality Conversations.

Monthly PIC reports:

The Quality Department and Community Service Managers within St. Patrick's Centre (Kilkenny) have developed a monthly report template which will support and ensure the management and governance between the CSM and PIC.

The monthly report template is completed by the PIC on the last Friday of the month and is basis for the monthly Quality Conversations between CSM and PIC.

Training:

The CSM and PIC are attending the Quality Training Sessions which are rolled out within St. Patrick's Centre (Kilkenny) to build capacity around HIQA standards, notifications, regulations, risk assessment, restrictive practices and file management.

Audits:

The PIC will ensure that audits are carried out as per SPC schedule. The PIC has delegated the completion of audits as per delegated duties and is reviewing audits and action plans with each employee through Quality Conversations.

The Director of Service, the Community Service Managers and Quality Department have met on the 23/08/2019 to ensure completion of annual and 6 monthly provider audits within St. Patrick's Centre (Kilkenny) and developed a schedule to complete same.

The Community Service Manager is currently completing a 6 monthly provider audit which will be finalised by the 30/09/2019.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The updated Statement of Purpose is now available in the house folder system in the designated centre. This Statement of Purpose reflects the current application to vary the registration for Parkview.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Corporate Governance Manager of St. Patrick's Centre (Kilkenny) is currently reviewing and updating the Complaints Policy. The updated version of the complaints policy will be available by 01/10/2019 and distributed to all designated centres within St. Patrick's Centre (Kilkenny).

The PIC will ensure that all staff have read, understood and signed the policy. This will be evidenced through team meeting minutes and signature sheet.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure the privacy of a person supported in the upstairs apartment of Parkview the PIC completed a resource form for the purchase of a suitable Perspex for the bedroom and second sitting room window.
The PIC is awaiting confirmation from the Finance Officer to purchase the Perspex. The maintenance team will ensure application of same.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The PIC and staff team are currently reviewing the risk register and all individual risk assessments in Parkview to ensure all risks are identified, rated and reflected in the risk register. The PIC attended the Quality Training Session around Risk Management on the 11/07/2019. Further training is scheduled for staff members to attend on the 18/09/2019 to build capacity within the staff team around identification, rating and reviewing of risks. A risk management working group within SPC has developed a new risk assessment form and risk register, which is currently being rolled out within SPC. The risk management policy is under review and will be finalised in September 2019 to reflect the new assessment and review process for risk assessments. Risk assessment within SPC will then be reviewed on a yearly basis or as required indicated by the identified actions within the risk assessment form. The review of generic and individual risk assessments in Parkview will be completed by the 30/10/2019. The new risk register will be developed and kept live reflecting all review dates.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Personal Plan: The current person supported's files are not reflecting person centred planning and make documentation of roles and goals difficult. Therefore the Quality Department and Community Transition Coordinators have developed a new Personal Plan folder system for St. Patrick's Centre (Kilkenny). This personal plan is outcomes based and will ensure that person centred documentation evidences progress of goals and roles. The new Personal Plan folder system is currently being rolled out within St. Patrick's Centre (Kilkenny). Workshops for CSM's, PIC's and keyworkers were delivered on the 4th, 5th and 11th September to ensure transfer from the older filing system to the new Personal Plan folder. Each person supported's documentation will be available in the new Personal Plan folder, additional daily logs will be available in a daily working file from the 11/09/2019 onwards.	

Visioning/Roles/Goals:

A new visioning documentation toolkit (roles based planning toolkit) has been developed within St. Patrick's Centre (Kilkenny) and was rolled by the Community Inclusion Coordinator through workshops in July 2019, which the PIC and a staff member attended.
The PIC will introduce the new roles based planning toolkit to the staff team at the team meeting on the 19/09/2019 and will also discuss be discussed individually with all keyworkers at Quality Conversations.

The PIC has scheduled a review of visioning meetings for both people supported in Parkview, using the new roles based planning toolkit in September 2019. The Community Service Manager, family members, the PIC, staff members and the people supported will be invited to the review meetings.
This will ensure that developed roles and goals can be reviewed and discuss and agree the introduction of new roles and goals.

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	03/09/2019
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	11/10/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	15/10/2019

Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	27/08/2019
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	15/10/2019
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	03/09/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and	Not Compliant	Orange	30/09/2019

	shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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	30/10/2019
Regulation 03(3)	The registered provider shall make a copy of the statement of purpose available to residents and their representatives.	Substantially Compliant	Yellow	02/09/2019
Regulation 34(1)(b)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall make each resident and their family aware of the complaints	Substantially Compliant	Yellow	30/09/2019

	procedure as soon as is practicable after admission.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	10/10/2019
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	10/10/2019
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances,	Not Compliant	Orange	10/10/2019

	which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	10/10/2019