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

Issued by the Chief Inspector

Name of designated centre:	Centre 8 - Cheeverstown House Community Services (Kingswood/Tallaght)
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	07 February 2022
Centre ID:	OSV-0004131
Fieldwork ID:	MON-0035280

About the designated centre

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

This designated centre is registered to provide full-time residential care and support for up to 12 male and female adults with an intellectual disability. The centre consists of five separate units in the community in a large town in Co. Dublin. There are three two-storey residential homes in the community, one single-occupancy apartment in an apartment complex and one level-access house. There are gardens to the rear of each of the houses and a small but secure patio area at the back of the ground floor apartment. Each of the residents living in the centre has their own bedroom which can be personalised to their own taste. The centre employs sleepover staff, social care workers, nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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
Monday 7 February 2022	10:00hrs to 16:50hrs	Gearoid Harrahill	Lead
Monday 7 February 2022	10:00hrs to 16:50hrs	Marie Byrne	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet with six of the eleven residents of the designated centre as they were at home, while other residents were out in the community or at day services. Some residents did not wish to speak with inspectors and this was respected. As the inspectors visited their home early in the morning three residents were sleeping in late as per their preferred routine, and some briefly said hello to the inspector. Two residents were up and having their breakfast. After they finished their breakfast they had chat with the inspectors. One resident talked about how long they lived in the centre and what it was like to live there. They said that overall they were happy living in the centre and that they felt safe. They showed the inspectors their bedroom which was decorated in line with their preferences. They had sufficient storage for their personal items and had their family photos and personal items on display.

One resident talked about how important it was for them to be independent, especially in relation to cooking their meals and travelling independently. They talked about their love for shopping and about how close they lived to one of their favourite shopping centres. They told that inspector that even though they loved being independent there was also a comfort in knowing the staff were there if they needed any support.

Each resident had private single bedrooms which were of sufficient size and were personalised and decorated based on the residents' choices. The service had ceiling hoists, accessible bathrooms and support rails for those who required them. Communal areas were spacious and some houses had multiple options of where to spend their time in the house. The service had pleasant back gardens which allowed for privacy. The service had the use of two suitable vehicles for residents to easily get to their appointments, social activities and their local community. Residents had commented that they were not satisfied with doors automatically closing due to their inability to open them, their preference to keep them open, and their preference to be in proximity or earshot of staff members at night. This will be commented on later in the report. The provider was in the planning stages of temporarily relocating residents while renovations took place in their home, to prepare residents for the move and ensure they had all their preferred belongings and clothes with them.

There was information available and on display in the houses in relation to the availability of advocacy service, residents' rights, making complaints, and raising concerns if residents felt unsafe or unhappy in their home. Inspectors observed a friendly and relaxed atmosphere in the house and a good rapport between residents and staff.

The next two sections of this report will 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 provided.

Capacity and capability

The focus of this inspection was to determine the progress of the actions identified by the provider to meet regulatory compliance following an inspection in September 2021. While there were still a number of outstanding issues, evidence was provided of how the provider was coordinating the plan of works to ensure that the residents were sufficiently supported during the premises renovation. The provider had also shown some improvement in resource management in the designated centre and had made some developments in moving towards compliance with staffing matters.

A new person in charge had commenced in the role in November 2021. They had been promoted to the role from within the staff team so were familiar with the residents, staff team and ongoing risks related to this designated centre. They held the appropriate level of experience and qualification required for the role. From engaging during the inspection and in reviewing minutes and correspondence from the person in charge, inspectors found good examples of them raising issues to management and outside parties, and following up on same to be advised of their status. They worked full-time in this role, which allowed for more effective oversight of a designated centre consisting of five addresses.

There were 2.5 full-time posts vacant from the staffing complement at the time of the inspection, and inspectors found evidence that there had been some improvement in how the interim arrangements to fill these posts mitigated the impact on the continuity of support for residents. Staff who spoke with inspectors said that there had been some improvements in relation to the consistency of staffing in the houses, and that there had been a decrease in the number of occasions on which staff were moved from one house to another during shifts. There had also been a decrease in the frequency of times in which residents who required the support of two people did not have two staff members available to them.

Inspectors reviewed a sample of weeks from the worked rosters and found that improvement was still required to identify who on the roster was part of the core team for the house, who was a member of the relief support team, and who had been redeployed from other locations and services. However, there had been a significant reduction in the number of shifts marked as 'unfilled' on the rosters. Where agency personnel were required, the same people were assigned to the houses who had worked in the service before.

There was a supervision schedule in place to demonstrate that each staff member would have an opportunity to have at least two supervision meetings and a performance management meeting in 2022. There were some gaps in mandatory training refresher courses, with 13-20% of staff overdue for training in areas such as fire safety, safe manual handling and supporting residents with behavioural

needs. However there was a date booked for all outstanding staff to attend these session in the coming months. Staff had completed courses in infection prevention and control as well as supplementary training courses based on the assessed needs of the residents, such as supporting people with epilepsy, dementia and autism, palliative care and supporting people with intellectual disability during times of bereavement.

Since the previous inspection, the provider had now arranged for the designated centre to have exclusive use of two vehicles suitable for the residents, when they had previously shared with other services, impacting on ready access to the community. The person in charge had arranged that staff of each house will have use of the vehicles on specified days and for the teams to plan weekly schedules, activities and recreational outings with the residents based on which days they had the car available. The provider was in the planning stage of identifying where residents would be temporarily accommodated while renovation work is done on their houses. The person in charge and the provider management had been in contact with the relevant services to ensure that residents' support equipment and preferred personal items would be available to them in their temporary accommodation. While the provider had established what works needed to be completed and how long they would expect it to take, the management on inspection was unable to confirm a date by which they expected the work to start and finish to provide assurance of when they expected to be in compliance with the relevant regulations. After this inspection, the provider was advised to provide formal written assurance of when these works would be completed.

Regulation 14: Persons in charge

The person in charge worked full-time in the designated centre and was suitably qualified and experienced for their role.

Judgment: Compliant

Regulation 15: Staffing

There were 2.5 full-time vacancies in the service, and there had been some improvement in continuity of familiar staff support until these posts were filled. There had been a decrease in occasions on which staff changed houses during their shift, and a decrease in times in which residents did not have the appropriate level of staffing as per their assessed needs. Some improvement was required in the worked rosters, to accurately identify shifts which were not filled, and which personnel were part of the core team of staff and who was deployed from other services.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Overall staff had received training suitable for their respective roles, however some staff were overdue to attend refresher courses in mandatory training such as safeguarding vulnerable adults, fire safety and behavioural support. There had been review of supervision structures to provide assurance that each staff members would have the opportunity to attend suitable supervision and performance management sessions with their line managers.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were a number of items required to come into compliance with regulations which were still outstanding without expected completion dates, based on the findings of the provider's own reviews and the findings of the inspectors on previous inspections, however there was evidence available on how these works were being coordinated to retain quality of support for residents during the renovations. There had been improvement in resource management since the last inspection, regarding staffing needs and access to suitable vehicles. The management arrangements had improved following the appointment of a person in charge who was full-time in that role.

Judgment: Substantially compliant

Quality and safety

The provider had had an external audit to identify the full extent of the works to come into compliance with fire safety requirements while other premises matters will be addressed. Many of the areas for improvement found on the previous inspection and by the provider in their own assessments remained outstanding.

Since the previous inspection, the provider had commissioned an audit of the designated centre by an external fire safety engineer. This audit took place in November 2021 and while the full report had not yet been issued to the provider at the time of inspection, the auditor had identified some of their key findings for attention by the provider. This included a requirement to review the fire containment rating of the walls, ceiling and floors, and the upgrading of the alarm

system in some of the houses. It had also been identified that a number of the fire containment doors were wedged and propped open and recommended that external fire doors were amended to not require keys in the event of an emergency evacuation. Doors along evacuation hallways were not all rated and equipped to contain the spread of smoke and fire in some areas of the designated centre. In parts of the designated centre which had been equipped with self-closing fire containment doors, these were to be observed wedged or propped open throughout the day. This was done based on residents' preference to have their bedroom doors open, or to allow residents using mobility equipment to easily navigate their home. For these reasons, doors to the kitchen, utility room, bedrooms, living rooms and dining rooms were held open with various types of wedges and furniture. Improvement was required to ensure that these doors could be held open by choice or by necessity, without compromising their ability to close in the event of a fire alarm.

Since the previous inspection, the provider had revised the evacuation plans of some residents so that suitable guidance was provided on their support needs. Practice evacuation drill reports had also improved, and the provider had conducted some practice evacuation drills simulating high risk scenarios, such as night-time staff levels, and including residents with higher support needs. Evacuation signage was clearly identified, and most of the doors requiring keys had emergency keys readily available, however inspectors identified evacuation routes leading to a locked gate for which staff on duty could not find the key. As part of the plan following their fire audit, the provider had committed to replacing key locks with thumb-turn latches where it was safe and suitable to do so to reduce this risk.

The provider had identified in their own audits that some areas of the designated centre required renovation to ensure the suitability and accessibility of the premises for the residents. These works included the addition of ramps and wider doors for residents with mobility support requirements, and the renovation of two bathrooms to provide a suitable space to meet residents' needs. It had been identified on the September 2021 inspection that there had been limited or no progress on these works based on timelines set out by the provider, and this was also found to be the case on this inspection. While the larger premises works were planned to take place later in 2022, other maintenance works such as addressing damage to paintwork, plaster, tiling, damaged doors and ceilings had also not been addressed.

There was a folder available for resident and staff which contained information of hand hygiene, the use of face masks, national guidance documents and the provider's policies, procedures, guidelines and protocols in relation to infection prevention and control. These included a monitoring and escalation tool and protocols should residents present with any signs or symptoms of infection. There was also a sample care plan template for residents who had suspected or confirmed cases of COVID-19. One resident told an inspector what they would do to keep themselves safe against infection while they were out and about in the local community. This included washing or sanitising their hands regularly, maintaining social distance and wearing a suitable face covering. There was easy-to-read information available in relation to areas such as contact tracing, COVID-19 precautions, social distancing and the use of face coverings. There had been a good

uptake among the residents and the staff of vaccinations against COVID-19.

An outbreak summary report had been completed following a recent outbreak of COVID-19 in one of the houses which affected a number of residents and a number of staff. This report reviewed how residents presented with symptoms, meetings that occurred, and public health communications. It identified what worked well and lessons learned. A further review was planned after the inspection to capture residents' views and an overall outbreak review. Plans were in place to share learning from this report at the next staff meeting. There was a table in the hallway of the houses visited which contained personal protective equipment, hand sanitiser and a thermometer. There were systems to check residents, staff and visitors for signs of infection or high temperatures.

Some improvement was required to ensure appropriate management of clinical or sterile equipment. In one medication area, blood pressure cuffs were found trailing on the floor, and a sharps box used for the disposal of items such as needles and cannulas was not closed when not in use. Some aspects of the premises work required impacted on the ability to maintain good infection control practices. The damage to the kitchen ceiling had resulted in paint chipping above food preparation areas. There were damaged areas of the kitchen and bathroom which were affecting the ability to properly clean and disinfect, for example, broken tiles and damaged surfaces and counter tops. The residents' shower and shower enclosure did not appear to be clean. In one resident bathroom there was a substantial build-up of black mould and mildew on the ceiling, walls and windowsill. Residents' personal hygiene products were stored on shelf with what appeared to be black mould on wall directly behind them. A resident's dentures were stored in an open container on the windowsill which appeared to have back mould on it. The inspectors issued an immediate action to the provider for this to be addressed. In the days following the inspection, the provider supplied photographic evidence that this mould had been treated and cleared and that the bathroom had been deep-cleaned and repainted.

Regulation 17: Premises

A number of areas were not in an ideal state of maintenance in the designated centre, including damage to paintwork, plaster, floorboards, bathroom tiles, room doors and ceilings. Renovation was required to the premises to ensure that it was suitable for the assessed needs of residents, including the addition of ramps, wider doors, and suitable bathrooms. The residents' access around their home was greatly compromised by the addition of self-closing fire doors, without also adding a means to keep them open safely due to residents' choices or mobility requirements.

Judgment: Not compliant

Regulation 27: Protection against infection

Some areas of the house could not be effectively cleaned and sanitised due to peeling, chipped, worn or damaged surfaces. One resident bathroom had not been kept clean and inspectors found there to be a visible and substantial build-up of mould and mildew on walls and shelves.

Judgment: Not compliant

Regulation 28: Fire precautions

Some areas of the designated centre required improvement to ensure that doors, walls and ceilings provided effective containment in the event of a fire. Room doors in the centre were either not equipped to close in the event of a fire, or were wedged and propped open compromising their containment features. Improvement was required to ensure that where evacuations routes included locked doors and gates, that these could be quickly unlocked during an evacuation.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Centre 8 - Cheeverstown House Community Services (Kingswood/Tallaght) OSV-0004131

Inspection ID: MON-0035280

Date of inspection: 07/02/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Person in Charge along with the Social Care Leader reviews the roster in accordance to the support needs of each client in each houses. • Staffing levels are being looked into on a four-week roster. Worked roster report represents colour coded strips to identify personnel covering vacant shifts i.e. support panel, overtime, etc. • A workforce meeting takes place to evaluate recruitment status for staff vacancies; vacant post are at recruitment stage. • A staff toolkit such as Employment Control Framework is in place which reflects current staffing and vacancies for each house along with current funding needed to monitor budget to be applied for staff recruitments.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person In Charge in coordination with Quality and Training Department monitors outstanding Mandatory and person specific training needs for staff based on clients assessed need • All Staff due for Trainings- both contracted and support panel staff - had been identified and are booked as follows:1 staff due for Fire Safety Training booked – 05.04.22; 3 Staff for Safeguarding of Vulnerable Adults via Hseland to comply by	

31.03.22; 2 Staff for Safety Intervention Refresher booked by 14.04.22
• Staff specific Staff Behavioural ManagementTraining for 2 Houses had been delivered by Psychology team- First Session done last 09.02.22 and Second session done last 01.03.22. A correspondence had been likewise sent to all staff to update as required Non-Mandatory Staff specific training on Infection Prevention and Control, CPR, First aid ELK, Epilepsy, Autism, Dementia ,etc through HSEland or as provided by the Organization.
• A monthly correspondence is given to all staff for Trainings Schedules especially Mandatory ones
• A current Staff supervision log sheet is in place reflecting schedules for Supervision of each contracted staff. The Person in Charge along with the Social Care Leader will oversee this and ensure 2 Staff Specific Supervisions are done from year commencing 26.03.22 and one Personal Development Plan at the end of the year.
• Person In Charge along with Social Care Leader will monitor each Supervisee's outcome and follow up an action plan as needed to support staff development. This will be reflected on each staff performance evaluation by 21.12.22.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• An emergency meeting conducted by the Head of supported Living Services, Quality Compliance Officer and Person In Charge took place last 09.2.22
• Funding for scope of works needed had been secured by the Registered Provider; contractor had been engaged; pace of works overseen by Facilities Manager and Director of Operations for renovations to be done particularly in two houses (House A&B) to address resident's needs.
• Resident's meeting about details of works, duration and relocation to a short term accommodation conducted by Person In Charge and Keyworkers took place in House A last 11.02.22 . A correspondence of the plan were likewise sent to families. Same will be done when works will be commissioned in House B.
• Works commenced in House A last 28.02.22 with a plan to implement a phased approach to progress on proceeding with works in House B.
• After relocation, a resident's meeting was conducted by Person In Charge last 03.03.22 and every 2 weeks thereafter to update on progress of works and for a feedback of how residents settle with temporary accommodations. Housekeeping manager liaise with residents to offer choices on certain interiors and paints with their current house renovation.
• Meeting between Facilities Manager, PPIM , Head of supported Living services, OT, Person in charge and Builder to plan ahead with schedules for works in House B to be done on 29.03.22.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Works commissioned for House A as follows:
• remove bath and replace with access shower
• Remove steps from the backdoor and replace with accessible ramp and handrails
• Provide double doors and access ramp leading from front downstairs bedroom
• Repair of Kitchen Ceiling

Works commissioned for House B as follows:
• Revise ramp access from downstairs bedroom
• Conversion of downstairs ensuite toilet and shower room into jack and jill type with shower area tray to be widened to facilitate easy access for both residents' personal care needs
• Removal of bathtub to be converted into a wet room with no steps for resident's safety in upstairs bathroom adjacent to landing
• Replacement of carpets in stairs and upstairs landing
• Repair of Gaps on timber floors
• Repair of Kitchen Ceiling

Works currently in progress for House A from commencement last 28.02.22 with a six-week duration as per builder's estimate. Works commissioned for House B are then to follow.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Immediate remedial works to remove molds in toilet in one house done last 08.02.22
• Current works on premises are being done to address areas affecting Infection Prevention and Control such as repair of kitchen ceiling in affected houses; toilet renovations and paintworks from 28.02.22
• A more effective extractor fan has been/will be installed in toilets of houses concerned and is included in the scope of works.
• All cleaning routines are to be reviewed and a comprehensive checklists to be re-established
• An Infection Prevention and Control Audit Tool is in place across all locations to be completed by staff and housekeeping manager bi-annually commencing 10.04.22 with an action plan to be reviewed and implemented

• An IPC lead to be identified to all houses and IPC Policy and Guidelines are to be discussed in house meetings commencing 20.04.22. • Areas of concern that needs to be addressed as per Cheeverstown Infection and control Policy will be actioned and followed up in order of priority in relation to the risk.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Hold-open devices meeting Fire Compliance will be installed in living , dining , kitchen and bedroom doors. The type chosen will be guided by resident's support needs and preferences. These devices will be connected to the fire alarm system • Double doors will be installed in one of the houses to facilitate safer evacuation route for one of the residents and comply with Fire Safety Regulations. This is included in the current scope of works. • A revised ramp access to be installed in downstairs bedroom in one of the houses to enable quicker evacuation route in one resident's bedroom • Personal evacuation Plans had been reviewed for each residents last 14.02.22 • Fire detection system and emergency lighting are in place in all houses with a Fire log checklist • Fire Equipment are in place in designated house areas and are serviced annually, next due 20.07.22 • Daily Fire Checklists are done by staff and Weekly Fire Checklists are done by staff and confirmed by Person In Charge.	

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	12/06/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/06/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	15/05/2022

	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.	Substantially Compliant	Yellow	15/06/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/09/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/09/2022
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He.	Not Compliant	Red	30/11/2022

	she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	01/07/2022
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	01/07/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting	Not Compliant	Red	31/05/2022

	procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	30/06/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	30/11/2022