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:	Lunula
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	01 March 2022
Centre ID:	OSV-0007900
Fieldwork ID:	MON-0031367

About the designated centre

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

This house a three bedroom bungalow located in Co. Kilkenny. The house is located on its own site; it has ample parking spaces and a secure garden. The house comprises of 3 bedrooms, one of which is en suite , a sitting room, kitchen/dining room, utility room and a visitors room. It provides a service to three adult male residents who present with intellectual disabilities and complex needs. The house is staffed with a combination of nursing and health care assistants. This is a high support home, with a requirement for two staff during the day with a third to assist in accessing the community.The stated aim of the service is to develop services that are individualised, rights based, and empowering, that are person-centred, flexible and accountable; services that energetically promote relationship building and social inclusion - and which are in and of the communities where people supported live.

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
Tuesday 1 March 2022	10:00hrs to 18:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with all three residents that lived in this centre. All three residents used different means to communicate, such as spoken language, vocalisations, facial expressions, behaviours and gestures. To gather an impression of what it was like to live in the centre, the inspector observed daily routines with residents, spent time discussing residents' specific needs and preferences with staff, and completed a documentation review in relation to the care and support provided to residents.

Overall, it was found that the care and support being provided was meeting residents' specific needs. Improvements were required across a number of regulations to ensure the quality of care could be maintained on a consistent basis. For the most part the level of improvement needed was self-identified by the registered provider and plans were being put in place to ensure this designated centre would meet the requirements of regulation.

The inspection took place during the COVID-19 pandemic. As such, the inspector followed public health guidelines. The inspector ensured physical distancing measures and the use of personal protective equipment (PPE) were implemented as required.

On arrival at the centre, it was noted that it was a well-maintained bungalow building, located in a rural location. The designated centre internally was well kept, warm, clean and tastefully decorated. Each resident had their own bedroom which was individualised. One resident's bedroom had an en suite, and the other two residents had access to a main bathroom. Each bathroom was fitted with accessible facilities such as hand rails and wet rooms. Outside there was a large garden area. As residents had only recently moved to the centre there were long-term plans to develop this space. In the interim, staff had been exploring different outdoor recreational options with residents to determine what was the best use of this space. For example, one resident was encouraged to plant flower beds. As this resident displayed a sustained interest in this activity, the option of purchasing a poly-tunnel was being explored.

The inspector was brought into the sitting room and had the opportunity to meet one resident that was relaxing in this room. They were up, showered dressed and had eaten their breakfast. They were listening to music and appeared relaxed in this room. They asked the inspector their name and mainly responded 'yes' or 'no' when asked any direct questions. In the kitchen the second resident was sitting on the couch drinking tea. Staff explained that this resident liked to have their tea before they engaged in any personal care routines in the morning. The third resident was still in bed. Observations and conversations with staff indicated a person centred, individualised approach to each resident's morning routine was well established.

The inspector spent some time in the kitchen observing care practices. The staff

during this time responded to each resident's specific needs appropriately. They were observed to frequently check in with the resident relaxing in the sitting room. This was completed in a natural manner and in line with the resident's specific needs. For example, staff were observed to ask if the resident would like some tea and checked in on them in terms of how they liked it. The second resident was being encouraged to leave the kitchen to complete personal care. The staff patiently explained to the resident what was happening, and objects of reference were introduced to help the resident with this transition. The staff were patient and caring with their interactions and instructions. The third resident came up to the kitchen briefly. They were helping with daily chores. This was part of the resident personal plan. Staff were seen to put on the radio when they came into the kitchen as this was important to the residents routine.

The residents enjoyed different levels of activities. All residents attended a day service for a number of sessions across the week. They enjoyed activities such as art, sensory activities or music. On the day of inspection, two residents left the home to attend the day service sessions. The other resident remained at home and was encouraged to engage in activities of their choosing. This resident was appropriately supported through different routines. Later in the day, after much encouragement from staff, the resident left the centre to go for a drive.

Overall, the quality of care residents were receiving was good and met each individual's specific needs. Residents appeared comfortable and content in their home. Improvements were identified across a number of regulations, such as oversight and monitoring arrangements, risk management, access to finances and safe evacuation of residents in the event of a fire. This is discussed in further detail throughout the report.

The next two sections of the report present the findings of this inspection in relation to the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspector found that the registered provider was committed to providing a service that supported residents according to their individual needs and preferences. There was a clearly defined management structure, with clear lines of accountability and responsibility. The registered provider had recently developed a service-wide quality improvement plan. As this plan was in its infancy, time was required for the measures to be embedded and have a noted impact on the quality of service provision for this designated centre. Improvements were required in relation to governance and management, notifications of incidents, training, fire safety, risk management, access to personal finances, and some aspects of the personal planning process.

Residents were supported by a team of staff that included social care workers,

nurses and health care assistants. There was a staff rota in place that accurately reflected staff on duty. There was a full-time person in charge who was responsible for two additional designated centres and divided their time accordingly. The management team appeared to have a regular presence in the centre and staff and residents were familiar with the person in charge. Staff were in receipt of regular training that enabled them to complete their role effectively. However, improvements were required in relation to arrangements around staff supervision.

There was evidence that the service was regularly audited and reviewed by the person in charge. They completed a number of different audits at set intervals across the calendar year. These audits reviewed personal plans, resident finances, fire and hygiene. Actions identified had been completed.

Provider-led audits such in the form of six-monthly unannounced provider audits were not occurring in line with the regulations. The last two provider unannounced audits occurred in January and December 2021. These tools were not being used to drive quality improvement from the provider level. This issue had been identified by the provider and there was a plan to ensure these audits were occurring in line with the requirements of regulation. In addition to this, oversight arrangements in terms of risk management and fire safety required further review from a senior management level.

While some of the notifications as required by the regulations had been submitted in a timely manner, it was noted that HIQA had not received a number of notifications. Observations on the day of inspection noted a small number of restrictive practices in place. These had not been notified for each quarter which is the current requirements under the Health Act 2007. In addition to this on review of the accident and incident reports for each resident a number of minor injuries and more significant injuries that required hospitalisation were not notified. These were retrospectively notified following the inspection.

Regulation 15: Staffing

There was a staff rota in place and it was reflective of the staff on duty on the day of the inspection. The provider ensured continuity of care through the use of an established staff team and a small number of regular relief staff. Agency staff was kept to a minimum and due to a full staff compliment, this was rarely required.

There was an appropriate skill-mix and numbers of staff to meet the assessed needs of residents. Residents were supported by a team of nurses, health care assistants and the person in charge. Staff were observed to be kind, caring and overall professional in there interactions with residents.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the staff training records. This indicated that the majority of staff had completed mandatory training in fire safety, safeguarding, manual handling, PPE, hand hygiene, food safety and managing feeding, eating, drinking and swallowing difficulties. Where staff required refresher training these were scheduled for dates in the coming weeks. The person in charge had a system in place to identify training needs and ensure all staff were booked on relevant training in a timely manner.

Supervision records known as quality conversations,were reviewed. One-to-one formal supervision was not occurring at intervals in line with the provider's own policy. The person in charge was aware of this. They had made an effort to complete supervision with a number of staff over the last couple of weeks. However, there were still no formal systems in place, such as a supervision schedule to ensure staff were in receipt of this as required.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider ensured there was a clearly defined governance structure within the centre which ensured that residents received a service which met their assessed needs. The registered provider had appointed a full-time, suitably qualified and experienced person in charge who was knowledgeable around residents' specific needs and preferences.

The provider had not always ensured that there was always effective oversight systems in place in this designated centre. As a result, staff supervisions, staff meetings and some audits had not been completed. Some provider-level audits and reviews as required by the regulations, and essential for senior management oversight, had not been completed as required. The registered provider had also identified this as an ongoing issue in a number of their services and had a long-term plan to rectify this which included utilising a specific on line auditing platform.

Improvements were required in a number of oversight systems to ensure that areas of quality improvement were being identified in a timely manner and that the service in place was ensuring optimal safety at all times. For example, the inspector identified a number of issues with oversight of risk and fire that had not been self-identified by the provider. This is discussed in further detail under Regulation 26 and 28.

Although there was a long-term plan to improve the oversight arrangements in this centre, these plans were in the early stages of development and required time to be

embedded and drive quality improvement.

Judgment: Not compliant

Regulation 31: Notification of incidents

Documentation in relation to notifications which the provider must submit to HIQA under the regulations were reviewed during this inspection. Such notifications are important in order to provide information around the running of a designated centre and matters which could impact residents. While some of the required notifications had been submitted, it was noted that HIQA had not received a number of notifications in line with the requirements of regulations. For instance, notification reports in relation to restrictive practices and minor injuries had last been submitted for Quarter 2 of 2021. No notification reports had been received for the latter half of 2021. Observations on the day of inspection indicated that some restrictive practices were in use in the centre and discussion with the person in charge confirmed the same. Incident and accident reports indicated a number of minor injuries had occurred for some residents over the previous six months and again the relevant reports had not been submitted. In addition to this, there were a small number of incidents in which a resident required hospital treatment for injuries sustained during falls. Again, these reports had not been provided to HIQA. Following the inspection the person in charge submitted the required reports.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and care was provided in line with each resident's assessed needs. A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review of personal healthcare plans, risk documentation, fire safety documentation, and documentation around protection against infection. The inspector found some evidence of residents being well supported in some areas; such as their healthcare However, improvements were required in relation to relation to evacuation procedures, risk management, access to personal possessions and reviews of personal plans.

The inspector reviewed a sample of residents' personal files. Each resident's health, personal and social care needs were assessed through an annual health assessment and visioning assessment. The residents had clearly identified person-centred roles

and goals. However, elements of resident plans had not been updated on an annual basis.

The registered provider took measures to ensure the residents' healthcare needs were met and reviewed regularly with input from health and social care professionals. Some residents presented with complex requirements in terms of their specific needs and the provider, person in charge and staff team were ensuring their healthcare needs were being met in the community setting. For example, in relation to one resident's specific needs a detailed information review was in place on a regular basis. This document was reviewed by the relevant health and social care professionals on a regular basis to ensure there specific needs were being met.

Although there were systems in place to assess and mitigate risks, such as a centre risk register and individualised risk assessments, on review of a sample of risk assessments it was evident that a number of risks were not being updated as required. For example, an orange rated risk had not been reviewed in over eight months. A number of incidents had occurred and although learning had been identified, this had not been documented in the relevant risk assessment. It was unclear if additional control measures had been introduced and were being effectively evaluated through the risk management processes.

The centre had suitable fire safety equipment in place, including emergency lighting, detection systems and fire extinguishers which were serviced as required. The residents had personal emergency evacuation plans in place which guided the staff team in supporting residents to evacuate. However, improvements were required to ensure that all residents could evacuate safely in the event of an emergency. One resident had failed to take part in a fire drill in the last six months. This risk had not been identified and no measures were in place on the day of inspection to address this. This had not been escalated and the oversight of this risk had not been sufficient.

Regulation 12: Personal possessions

The previous inspection had identified that residents did not have their own bank accounts. It also identified that assessments in relation to support around finances had not occured.This was ongoing at the time of the current inspection. The provider had made efforts to rectify this.They had set up a working group and the financial manager had made contact with a number of financial institutions in regards to this. The provider was still exploring what was available to residents to ensure any measures put in place would allow residents to have the most access and autonomy over their finances in line with their assessed needs.

Judgment: Not compliant

Regulation 17: Premises

The designated centre was built to ensure residents' assessed needs could be met. There were accessible bathrooms, wide corridors and bright and homely communal spaces. The premises was well kept both internally and externally. Each of the resident's rooms were tastefully decorated with family photographs and personal items on display.

There was a large back garden and plans were being developed to ensure this space would meet the need and interests of the individuals living in the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

Although there were risk management procedures in place in this centre, the oversight of risk management required review. A centre-specific risk register was in place which identified a number of specific risks and had been reviewed on a regular basis.

On review of the accident and incident records a number of reports were related to resident falls. For example, between November 2021 and February 2022 one resident had nine documented falls. They had a risk assessment in place, however, this was last reviewed in June 2021. Any learning identified from the accident and incident reports had not been reviewed in line with the relevant risk management policy.

In addition to this, some risks around fire had not been identified and therefore appropriate management of this area was not occurring. For example, as discussed under Regulation 28, a resident who failed to evacuate the premises had a risk assessment completed in relation to this. This had a low risk rating which was not in line with the current situation in place. This risk area required further review.

Judgment: Not compliant

Regulation 27: Protection against infection

There was evidence of contingency planning in place for COVID-19, with relevant guidelines and policies and procedures in place. All staff had adequate access to a range of PPE as required. There was sufficient access to hand sanitising gels and hand-washing facilities observed through out the centre. Staff had completed a

range of training to enable them to practice effective infection control measures.

Judgment: Compliant

Regulation 28: Fire precautions

Although there were systems in place of fire safety management such as suitable fire safety equipment, staff training, emergency exits and lighting, improvements were required to ensure residents' safety at all times. On review of the fire drills, it was documented that one resident had failed to take part in a fire drill in a six-month period. No specific learning or measures had been identified or put in place around this risk. The person in charge provided assurances that a fire drill would occur as soon as possible, where they would provide direct oversight and support to staff in relation to this matter and escalate accordingly.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of their health, personal and social care needs. The assessments informed the residents personal plans which were found to be overall person centred. The inspector reviewed a sample of residents' personal plans. A number of care plans had not been reviewed on an annual basis. This is the minimum requirement to ensure all plans are kept up to date and reflective of residents' specific needs.

Judgment: Substantially compliant

Regulation 6: Health care

The healthcare needs of residents were suitably identified. Health care plans outlined supports provided to residents to experience the best possible health. Residents were facilitated to attend appointments with health and social care professionals as required. Nursing care was in place on a regular basis.

Judgment: Compliant

Regulation 8: Protection

Appropriate measures were in place to keep residents safe at all times. Staff received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff spoken with, were found to be knowledgeable in relation to their responsibilities in ensuring residents were kept safe at all times. Residents had intimate care plans in place which detailed the level of support required.
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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Lunula OSV-0007900

Inspection ID: MON-0031367

Date of inspection: 01/03/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has completed all Quality Conversations in line with SPC policy. The PIC has developed a schedule for completion of QCs in Lunula, which is available in the folder and to all employees.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An annual and two six monthly provider audits had been completed and actions plans developed. A six-monthly unannounced visit took place in January 2021, followed by an annual unannounced visit in March 2021 to ensure follow up on actions identified and document progression of same. Due to the implementation of peer auditing system, COVID restrictions and change of auditors the next six-monthly unannounced visit has then taken place in December 2021. The PIC and staff team have been processing completion of the identified actions. The most recent six monthly unannounced visit has also been sent to the inspector on the 08/04/2022. Since the peer auditing has commenced a schedule for completion of provider audits is in place for annual and 6 monthly audits with assigned auditors and timeframes. Whilst some team meetings had not been taken place in late 2021, regular team meetings are facilitated in Lunula since January 2022. A schedule for team meetings for 2022 was in place on the day of the inspection and is followed. Most recent team	

meeting was held on 30/03/2022 with very good engagement of the team.

The PIC is in progress of completing all Quality Conversations in line with SPC policy. The outstanding QCs have been completed. The PIC has developed a schedule for completion of QC in Lunula, which is available in the folder and to all employees.

The PIC has implemented a new system to oversee delegated duties to ensure better oversight on tasks completed and issues arising regarding person supported's safety or quality of service provided. The PIC has delegated the completion of SPC audits to a team member. The team member has developed a system on how to mentor the Lunula team in understanding the completion of audits in line with schedule, feel responsible for follow up on actions and reporting back to the PIC.

The first 2 modules of SPC Management Development Programme were delivered to all PICs and PPIMs on the 23/03/2022 with focus on:
- The Human Rights Based Approach
- Leadership, Governance & Management

This overall 10 module programme will further build capacity and understanding within SPC line managers to ensure safe and good quality service for the people supported and focusses also on delegated duties.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All outstanding notifications have been completed and submitted by the PIC on the 04/03/2022.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
SPC has made contact with several financial institutions and were advised of the system that is available to the people supported in SPC to access their personal finances and explored options for the people supported to open their own bank accounts. The options offered by financial institutions do not increase the person's control or access to their finances compared to the current SPC system; in fact, it would actually reduce the availability and opportunity for people to have access to their own funds.

In line with Regulation 12 and 9, SPC is providing all efforts to support the people living in SPC to be supported and have access to their finances in line with SPC finance pathway. SPC Personal Planning Framework ensures that people are supported to exercise choice and control in their daily life.

A position paper will be submitted to HIQA to further outline the providers view on the above in line with Regulation 12.

On designated centre level the PIC and support team are further exploring with the gentlemen in Lunula to open their own bank accounts. Circle of support meetings will be held to explore with each person supported their approach. Since SPC has commenced roll out of Circle of support meeting training in April 2022, the PIC and also one designated employee from Lunula are part of this training to gain further understanding and competence.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC is meeting with the staff nurse for Quality Conversation on the 25/03/2022 to discuss further support and capacity building within the team regarding understanding of risk management and documentation of same.

The relevant risk assessment for a person supported in relation to most recent falls has been updated including learning identified.

The risk assessment for one person supported in relation to fire evacuation has been reviewed to ensure adequate risk rating. A review of fire evacuation in Lunula has taken place between the chief fire officer and the PIC on 10/03/2022 for a walk around. Callan fire brigade team visited Lunula on the 15/03/2022 to oversee evacuation for all people supported. Please also see response under Regulation 28.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC has discussed completion of fire evacuations at the team meeting on the 30/03/2022 to ensure the team understand how to complete fire drills, document

learning and feedback any areas of concern to the PIC.

A review of fire evacuation in Lunula has taken place between the chief fire officer and the PIC on 10/03/2022 for a walk around. Callan fire brigade visited Lunula on the 15/03/2022 to oversee ways of evacuation for all people supported and provide recommendations. The detail of this visit will be discussed also at the team meeting.

The PIC has also requested input from the Behaviour Support Specialist to explore further supports for a gentleman in Lunula regarding fire evacuation.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Social Care Worker has supported the keyworker of a gentleman to review and update all support plans to ensure they are reflective of the person's current needs.

As part of the Measurement Plan of the delivered Management Development Programme all PICs are reviewing the quality of person's roles and monthly review meetings. This will ensure a better oversight over completion of necessary reviews and keep support plans up to date.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	07/04/2022
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	01/04/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/04/2022

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.	Not Compliant	Orange	30/03/2022
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 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.	Not Compliant	Orange	30/03/2022
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	Not Compliant	Orange	25/03/2022

	risk, including a system for responding to emergencies.			
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.	Not Compliant	Orange	30/03/2022
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	04/03/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or	Not Compliant	Orange	04/03/2022

	environmental restraint was used.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	04/03/2022
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, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/03/2022