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:	Centre 5 - Cheeverstown Community Services (Hillcrest/Ballyroan)
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	09 December 2021
Centre ID:	OSV-0003556
Fieldwork ID:	MON-0029435

About the designated centre

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

This designated centre comprises of three two-storey community residential houses, all located between two towns in Co. Dublin. The centre provides care and support to men and women with intellectual disabilities over the age of eighteen. The designated centre has capacity for 11 individuals in total. House One can provide full-time residential care for three individuals. The house consists of four bedrooms with one bedroom having an en-suite bathroom, and a further shared bathroom and additional toilet facilities downstairs. There is a kitchen, dining room and sitting room with a garden area out the back. House Two can provide residential care between Monday and Friday for up to three female individuals. The house consists of four bedrooms, a dining room, a kitchen and sitting room. One bedroom has an en-suite bathroom and there is a shared toilet and shower upstairs and a downstairs toilet. House Three can provide full-time residential care for five individuals. The house consists of staff and resident bedrooms, a kitchen/dining area and a sitting room with an elevator. There are two bathroom/shower rooms with toilets upstairs including a downstairs toilet. There is a garden area out the back. There is shared transport available to book for all houses. The person in charge shares their working hours between the three houses within the designated centre. There are staff nurses, social care workers and core support staff employed in this centre to support the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Thursday 9 December 2021	10:00hrs to 20:00hrs	Gearoid Harrahill	Lead
Thursday 9 December 2021	10:00hrs to 18:00hrs	Sarah Carter	Support

What residents told us and what inspectors observed

During the day, the inspectors had the opportunity to meet with the people living in the designated centre and their direct support staff, as well as observe support and interactions, and review documentation on resident participation with the service. The residents were aware of the inspection process and welcomed the inspectors to see their home.

The inspectors met with seven of the nine residents currently living in the designated centre. This included residents who had come home in the afternoon from day services, community activities and their places of work, as well as residents who were relaxing and engaging with their hobbies around the house.

Residents lived in residential houses in suburban areas and had been supported to personalise their living space with preferred furniture, photographs, posters and artwork. Residents who required equipment to safely navigate had space to store it without obstructing others. The provider had installed a platform lift in one house for residents who wished to continue living in the house but were unable to climb the stairs. At the time of the inspection, one resident was being supported to rearrange and refurbish their bedroom to better suit their navigation needs. Residents had full access around their house and the ability to lock their bedrooms when they were not home to protect their own private space. Residents had spacious and private gardens to the rear of their houses, which was used to play sport, and keep up their skills for the various sports clubs they participated in, and do work in the garden.

Residents were supported to enhance their independence and life skills in the house and in the community. Residents were working on objectives related to independent meal preparation and laundry, safe use of public transport and online shopping, and were supported to manage and budget their money in accordance with their assessed needs. Some residents had paid employment or voluntary work, and others were involved in advocacy services within the provider group. Residents were supported to attend their community engagements, appointments and visits with family and friends through booking the use of vehicles shared with other services, or private taxis. Staff and residents indicated that spontaneous outings and day trips could be further facilitated through exclusive access to vehicles belonging to the designated centre which would also reduce the need to pay for regular taxis. This was a project towards which the service provider was in the process of attaining funding.

Residents commented that they were looking forward to Christmas. Traditionally residents would attend the service provider's central campus for a Christmas event. While this could not take place as normal due to COVID-19 precautions, residents had Christmas dinners delivered to their home and the inspectors observed residents and staff enjoy this together later in the evening.

The inspectors observed patient, friendly and encouraging interactions between the residents and the staff contracted to work in the houses. The staff met on inspection displayed a good personal knowledge of the residents' personalities, histories and preferences. Inspectors also observed good examples of staff being knowledgeable of the communication styles of residents who did not primarily use speech, to support conversation between the inspectors and the residents, and support them to communicate their news and talk about themselves. This included the use of photos and signed gestures between the staff and residents.

Residents commented that they felt safe in their home and named their preferred staff in the event they ever felt unsafe or unhappy in their home, and the inspectors observed an overall relaxed atmosphere in the centre. Residents told inspectors that they had staff with whom they enjoyed working, however, they did not always like the staff who were deployed to work with them on some days from other houses or from the relief arrangements, who were less familiar with their support needs and routines. Residents commented that they didn't like when last-minute changes to the expected staff were made, including examples of when they were told on the same day that they would be supported by someone other than the person planned. Examples given included residents who didn't like when staff didn't follow their preferred hair and nail care, or when staff would be less able to understand them. Staff supporting residents also indicated where residents would not get along with some staff over others, would not engage with their routine or would get frustrated or agitated when supported by unfamiliar staff or staff they did not like. Staff and residents commented that these changes occurred regularly.

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

Capacity and capability

The inspectors found that there was development required to secure the consistency of support delivery for residents' needs and rely less frequently on contingency arrangements to supplement the resources of this designated centre. Assurance was also required regarding the discrepancy between the quality of service reported though commentary from residents and their direct support personnel, and the findings of the service provider's oversight and reporting. A number of areas identified for improvement on this inspection were repeat findings from inspections which had taken place in 2019 and 2020.

At the time of the inspection the provider had one half-time vacancy in the staffing complement for the designated centre, with a designated panel of core relief personnel equivalent to 1.5 whole time hours for covering annual leave and unexpected sick absences. Staff were supported to complete their induction, one-to-

one supervision, and mandatory training in accordance with the required time frames, with examples found of dates booked to secure refresher training for those approaching their expiry times. This also included training in specific skills relevant to the residents' assessed healthcare and social care supports. The inspectors reviewed a sample of personnel files and found them to contain the required information under Schedule 2 of the regulations including vetting by An Garda Síochána and evidence of qualifications.

In reviewing a sample of months from the worked roster, inspectors found that the service regularly relied on multiple contingency arrangements to achieve the number and shift patterns assessed as required to meet the support needs of the residents. In addition to the core support personnel, additional relief staff were deployed to the service, as well as staff relocating to other houses within the centre, or coming in from other designated centres. Staff also indicated that they were often required to stay later or start earlier than their rostered hours, be called in to work while off duty or on annual leave, or work consecutive sleepover shifts over a number of days in order to fill shifts. Short-notice changes made to staffing times and locations was observed by the inspectors on the day of inspection. From observing the rationale for changes and speaking with staff and residents, inspectors found that these changes were primarily accommodated by staff to ensure that residents' needs were met. Examples included staff coming in earlier that their rostered time to ensure that the house was tidy and set up as per the residents' wishes before they arrived home from day service, or arranging taxis so that residents would not miss work or their appointments. While residents' supports were being delivered, quality reviews of the service had not highlighted that the designated centre's own resources were not sufficient in achieving this, and were regularly contingent on short-notice rearrangements, staff overtime, and external personnel and transport facilities. Review was also required to the centre's staff rosters; in the sample reviewed there were many examples of shifts in which it was not clear if the shift was filled and by whom, when the service used personnel from the relief team or other designated centres, when staff moved between houses or what times they finished. The rosters also used colours and symbols whose meaning was not clear, including where they denoted that scheduled shifts listed did not occur due to unplanned leave.

The provider had conducted their annual and six-monthly review of the quality of the service in the designated centre. The review highlighted the challenges posed by COVID-19 and the commitment going forward to reintroduce new and returning social and community opportunities for the residents after social restrictions began easing and residents had been vaccinated. These reviews reflected how resident independence had been facilitated through risk assessment for staying home alone, managing their own money, and upskilling in laundry and food preparation. The provider acknowledged the requirement to enhance continuity of staffing support, however, there was limited reflection on the need to revise shift patterns, access to transport, and frequent reallocation of staff times and locations based on the direct feedback and commentary of the residents and staff in the houses. Overall the inspectors found there to be a discrepancy between the feedback on service quality of the provider management, and that of the people living and working in the houses. It was also not consistently evident how staff were formally raising their concerns to their respective line managers, nor how commentary from the residents

and staff was being reflected and incorporated in the review of service quality, to give effect to plans to improve the service based on the feedback.

Some improvement was required on the consistency of how complaints in the service were recorded and trended. There were multiple locations in which complaints were logged which contradicted one another. For example, the log of complaints and responses in one house stated that no complaints had been made for all of 2021. However the minutes of multiple house meetings indicated that residents were regularly using these meetings to raise their complaints and feedback, including their commentary on staffing resources. The person in charge also had a separate record which included other complaints not reflected in the onsite log, however, this record included examples of how concerns had been discussed with the complainant and an outcome on the matter was reached. Depending on where complaints were raised or recorded, it was not consistently clear what actions had occured or what outcome had been communicated back to the complainant. The provider had acknowledged this inconsistency in team meetings and service reviews during 2021, as well reminding staff to ensure that all complaints addressed in-house were recorded and reported in line with centre procedure.

The inspectors reviewed the policies and procedures of the designated centre required under Schedule 5 of the regulations. While the provider had all the required policies in place, 10 of the 21 policies being used onsite had not been reviewed and updated within the regulatory time frame. This was a repeated finding from the previous two inspections of this designated centre.

Regulation 14: Persons in charge

The person in charged worked full-time, and was suitably qualified and experienced for the role.

Judgment: Compliant

Regulation 15: Staffing

Through observations, review of documentation and commentary from the residents and staff members, the inspectors found that revision was required to the complement, shift patterns and contingency arrangements to ensure that residents received appropriate and consistent staff support to meet their assessed needs, preferences and routines.

Review to the staffing rosters was required to ensure that they accurately reflected the personnel, times and locations worked in by staff in the designated centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were supported to attend training sessions required by the regulations and to support residents' assessed needs. Staff underwent induction, probation and supervision in accordance with provider time frames.

Judgment: Compliant

Regulation 23: Governance and management

A number of the areas for improvement found on previous inspections were found again on this visit, indicating that the actions taken by the provider had not been achieved within their stated time frames, or had not been effective in achieving regulatory compliance.

A review of the centre resources was required to ensure that the facilities, equipment and personnel of the designated centre were sufficiently available, continuous, and managed to meet the health and social needs of the residents, without being frequently reliant on contingency arrangements, short-notice changes, and externally provided services.

Review was required of how commentary and feedback from the residents and front-line staff was being reported to the provider and addressed in the provider's own service assessments of the quality of resident supports and service delivery.

Judgment: Not compliant

Regulation 34: Complaints procedure

Improvement was required to ensure that complaints raised in the designated centre were consistently recorded, that records on complaint oversight correlated to one another, and that the complaints addressed in-house or raised at resident meetings were managed in accordance with the provider's procedures, including being clear on outcomes reached and the satisfaction of the complainant.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Half of the policies and procedures required under Schedule 5 of the regulations had not been reviewed within the required time frames.

Judgment: Not compliant

Quality and safety

The inspectors observed good examples on this inspection on how residents were supported to be independent, receive support in accordance with their assessed needs, and make progress on their personal goals at home and in their community. The residents' houses were suitable in their design and layout for residents, however some review was required to enhance fire safety, maintenance and cleanliness of the designated centre.

The residents were supported in three two-storey houses. The inspectors found examples of how the layout of the house had changed to meet the residents' changing needs. For example, one resident was in the process of having their room rearranged and refurnished to be more able to comfortably get around with their equipment. A lift had been installed into one house so that residents whose mobility was decreasing, but who wished to stay in their house, could safely access upstairs. Residents had spacious and comfortable living room areas and had been supported to decorate their bedrooms how they wished. On the whole the centre was well-maintained, however some improvement was required to ensure that high surfaces such as the tops of furniture, ceilings and skylights were included in the cleaning regime. In one house there was some water damage to room doors causing their surface to peel, and some radiators required repainting. Overall supplies of cleaning products and personal protective equipment (PPE) was sufficient, with staff using face coverings and hand hygiene opportunities appropriately. In two of the houses, colour coded mops and buckets were clean and dry, with the poles clipped to the wall and the mop heads washed, however, in one house visited, the mops and buckets were found lying on the ground in the garden with leaves and dirt on them, and the used mop heads were still attached to the handles and not ready for that days' use.

The provider had evidence on how they were assured that an emergency evacuation could be achieved efficiently and that areas for potential delays were identified. In a sample of practice evacuations, residents and staff could exit the building safely in under a minute. The provider was in the process of having a formal review of the fire infrastructure of all premises in this provider group, and while the formal review had not yet taken place in these houses, the provider acknowledged that fire safety improvement was required in this designated centre. Not all doors along fire evacuation routes were rated to effectively contain flame and smoke or to close

automatically in the event of an alarm. Other doors were equipped to close automatically, but had been wedged or propped open for convenient access, instead of using means which would not compromise containment. All houses were equipped with emergency lighting, signage and firefighting equipment, and these had been routinely tested and serviced. Fire escape routes were not obstructed or locked, and each house had multiple routes to get to the assembly point efficiently.

Inspectors reviewed a sample of residents' comprehensive needs assessment and how these had been used to inform personal support plans. Staff guidance in these plans was detailed, person-centred, evidence-based and reflective of the input from the residents, their healthcare professionals and the experiences of their time in this designated centre. The plans had been reviewed within the past year and reflected changes in circumstances such as the impact of the COVID-19 restrictions on their access to their friends, family, day service, jobs and local community. Many of the residents' personal goals had shifted focus to life skills development objectives that were not as impacted by social restriction. This included increasing independence with cooking, laundry and household chores, managing money and establishing savings, and living with reduced staff support. The effectiveness of the plans was evaluated within the past 12 months, highlighting goal progress and the provider's assurance that residents can live independently for an assessed period of time and would know how to respond to an emergency.

Residents were invited to attend house meetings once a week. These were used to provide updates on the pandemic, plans out meals for the week, and raise concerns to staff. Some residents were involved in advocating for their peers. During the day, the inspectors observed staff treating residents with respect, privacy and dignity, as well as ensuring they had the skills to support others to understand and converse with residents who communicated by means other than speech. Residents were supported in houses which were free of environmental restrictive practices around the house, kitchen and gardens, and residents held their own keys to lock their own bedrooms if they wished to do so.

Inspectors reviewed a sample of medication protocols and found them to be appropriate in how medicines were prescribed, stored, recorded and administered to the residents with the correct dosage, time and rationale.

Regulation 10: Communication

Inspector observed staff and residents using simple language documents, picture boards, and signing gestures to support the resident to be understood by others and converse in accordance with their communication styles.

Judgment: Compliant

Regulation 11: Visits

The centre maintained a visitors log to monitor who was attending the houses and had precautions in effect to protect people from risks related to COVID-19.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had sufficient space in which to store their clothes and belongings and were supported to personalise their living spaces as per their wishes.

Judgment: Compliant

Regulation 17: Premises

Overall the premises was suitable in design and space for residents, however some areas required attention to ensure they were kept in a good state of maintenance.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Some improvement was require to ensure that surfaces could effectively be cleaned, and that cleaning equipment was itself clean, and stored appropriately.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Review was required to two of the three houses to ensure that internal doors were equipped to effectively contain fire and smoke. Where residents and staff chose to keep self-closing doors open for access, this needed to be done in a manner which did not compromise the containment features of the house.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The procedures for the prescription, administration, storage and recording of medication was clear and sufficient to guide staff on good practices.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' support plans were person-centred, informed by multidisciplinary needs assessment, and kept under review to monitor their effectiveness and progress towards resident objectives.

Judgment: Compliant

Regulation 8: Protection

Staff and residents were clear and regularly reminded on how to respond to an actual or suspected instance of abuse, and the provider could evidence action taken to respond to incidents reported to them in a timely fashion.

Judgment: Compliant

Regulation 9: Residents' rights

Resident privacy, dignity, autonomy and independence was found to be respected in the residents' home. Residents were provided the means to plan out their regular routine and personal goals as well as stay in contact with their friends, family and community.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Centre 5 - Cheeverstown Community Services (Hillcrest/Ballyroan) OSV-0003556

Inspection ID: MON-0029435

Date of inspection: 09/12/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC will respond to shift vacancies by covering vacancies where possible with regular contracted staff familiar to the residents for continuity of support. Vacancies will be brought through the Recruitment Process. All support staff and agency staff will receive induction to the location on the support needs of residents. The person in charge will ensure that there is a planned and actual staff rota showing staff on duty and ensuring it is updated when changes happen.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Registered Provider has assurance processes in place on overall Governance and Management. These processes will be reviewed specific to DC5 with regard to capturing the staff experience and service user experience in a demonstrable way. The PIC will review supervision of team members to ensure two-way communication. The agenda of team meetings will be restructured.	

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The concerns and complaints documentation within these homes will be reviewed to ensure it captures a record of all concerns, the outcome for the person and if the person is satisfied with the outcome. The PIC will communicate with staff to ensure they recognize dissatisfaction and capture the information on the appropriate documentation.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The organisation will review and update where necessary the policy and procedures as guided in Schedule 5 of the regulations.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The PIC will agree a maintenance schedule with the facilities manager to include repairs currently required and routine scheduled maintenance each year. Further discussion will be arranged with two external landlords to ensure premises are of good standard.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The PIC will agree a housekeeping schedule with the housekeeping manager to ensure cleaning schedules including the cleaning of areas/equipment that are not regularly used	

is up to date, appropriate and monitored.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Each of the three locations will be audited to ensure suitable hold open devices along with suitable self-closers are in place on those doors that require enhanced fire rating.	

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	04/03/2022
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.	Not Compliant	Orange	04/03/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	04/03/2022

	showing staff on duty during the day and night and that it is properly maintained.			
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.	Substantially Compliant	Yellow	01/04/2022
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.	Not Compliant	Orange	04/03/2022
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	25/03/2022
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and	Not Compliant	Orange	25/03/2022

	performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	25/03/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/04/2022
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	01/04/2022

Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	01/04/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	01/04/2022