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Cherry Orchard Hospital, OSV-0003730, 04 December 2018

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

Name of designated centre:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Dublin 10
Type of inspection:	Unannounced
Date of inspection:	04 December 2018
Centre ID:	OSV-0003730
Fieldwork ID:	MON-0025095

About the designated centre

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

The centre is based in Dublin and operated by the Health Service Executive. It consists of two buildings in close proximity to each other, within a hospital campus. Care and support is provided for 26 residents over the age of 18, both male and female with a disability. There are 20 long term residents and 6 respite beds. One building consists of two single bedrooms, five shared bedrooms, two bathrooms and two shower rooms, a dining room, day room, physiotherapy gym, multisensory room and an adjacent family room. The other building consists of three single bedrooms and four shared bedrooms. All bedrooms in this building are ensuite. In addition, there is a dining room, day room and family room. Support is provided for residents over a 24 hour period by registered nurses, healthcare assistants and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21
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How we inspect

To prepare for this inspection the inspector or 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
04 December 2018	08:05hrs to 16:35hrs	Marie Byrne	Lead
04 December 2018	08:05hrs to 16:35hrs	Ciara McShane	Support

Views of people who use the service

The inspectors had the opportunity to speak with four residents during the inspection. In addition, throughout the inspection, inspectors observed elements of residents' daily lives. Through observation the inspectors observed staff interacting with residents in a kind and respectful manner. Staff described how residents liked to spend their time including their preferred activities both at home and in their local community.

Residents who spoke with the inspectors were complimentary towards the care and support in the centre and towards the staff who supported them. One resident who spoke with the inspectors described their plans for social activities over the coming weeks including three parties. They told the inspectors how happy they were with their new bedroom and how they had decorated it. They had recently moved from a multiple-occupancy to a single occupancy bedroom.

Two residents described how they actively participated in the centre by acting as residents' representative on a number of groups and how important these roles were to them. They described how supportive staff were in ensuring they attended and contributed to these groups. One resident described how happy they were with the ongoing care and support they received in the centre. However, they voiced their concern in relation a perceived increased administrative burden for nursing staff in recent times.

Capacity and capability

Overall, the inspectors found that the registered provider and person in charge were striving to ensure a good quality and safe service for residents. In line with the findings of the last inspection there was evidence that the revised governance and management systems and structures, although in their infancy, had begun to bring about aspects of positive change for residents. Staff members' roles and the details of their responsibilities for the areas of service provision were in place. Oversight and monitoring arrangements remained in place, although there had been a decrease in the frequency of a number of management meetings since the last inspection and a decrease in the auditing of various aspects of the service. Further and sustained improvement was still required to ensure safe, consistent and effective delivery of care in accordance with residents' needs.

The staff team reported to the person in charge (PIC) who in turn reported to the person participating in the management (PPIM) of the designated centre. Staff meetings were held regularly and agenda items were found to be resident focused. The inspectors reviewed audits and found that there had been a decrease in

the number of audits completed since the last inspection. The frequency of which audits were to occur was also unclear. Improvements were required to ensure that the suite of audits were completed regularly to ensure that residents were in receipt of good quality and safe care. There was also a decrease in the number of formal meetings between the PIC and PPIM since the last inspection.

Residents appeared comfortable with the level of support offered by staff. The inspector spoke with six staff members during the inspection and found that they were all knowledgeable in relation to residents' specific care and support needs. The clinical nurse manager, director of nursing and registered provider representative facilitated the inspection, and the acting assistant director of nursing who is a person participating in the management of the centre (PPIM) and the quality and risk advisor attended feedback following the inspection.

There were two staffing vacancies at the time of the inspection. The provider was in the process of recruiting to fill these vacancies and the inspectors were informed that they were using regular agency and staff were completing extra hours to fill the required shifts. The inspectors reviewed rosters in the centre and found that it remained that they were not well maintained. The inspectors requested typed rosters to be sent for review following the inspection. On reviewing these rosters, the inspectors found that over a two week period there were five days one week and seven days the other week where there were not adequate staffing levels in line with the centres' statement of purpose and residents' assessed needs. On six days over the two week period the centre was operating one staff below the required staffing quota and on six days they were operating two staff below the required quota.

Staff had completed a suite of training and refreshers in line with the residents' assessed needs. It was evident that improvements had been made to levels of staff training since the last inspection. 100% of staff had now received fire safety, CPR, manual handling, infection control and safeguarding training. However, improvement was still required in relation to some of the staff training required to meet residents' needs including; 5% of staff requiring MAPA training, 50% requiring communication training, 5% requiring incident reporting and management, 6% requiring care planning and documentation, 10% requiring supervision training.

In line with the findings of the last inspection the procedures in place for formal staff supervision were in their infancy. They required further time to bed in and a number of staff were yet to receive formal supervision. The inspectors reviewed a number of supervision records which had been completed since the last inspection and found that they required review to ensure they were following the organisations' policy and procedures and supporting staff to carry out their duties to the best of their ability.

There were policies and procedures in place for the management of complaints which were on display and available in an accessible format. There was a nominated complaints officer and systems in place to investigate and respond to complaints. However, on reviewing a number of complaints the inspectors found that it was unclear as to whether some complaints had been resolved to the

satisfaction of the complainant. In others reviewed, it was recorded that the complainant was not satisfied and there was no evidence of further follow up to attempt to resolve the complaint.

Regulation 15: Staffing

Residents were observed to receive assistance in a caring, respectful and safe manner. There were planned and actual rosters in place. However, these rosters were not well maintained. There were two staff vacancies and the provider was in the process of recruiting to fill these vacancies. On reviewing rosters there were times when there were insufficient staffing numbers in line with the centres' statement of purpose and residents' assessed needs.

Judgment: Not compliant

Regulation 16: Training and staff development

Improvements had been made in the levels of staff training since the last inspection. However, a number of staff required training and refreshers in line with residents' needs as outlined in the body of the report. There were procedures in place for formal staff supervision but these were in their infancy and improvements were required to ensure all staff were in receipt of regular formal supervision to support them to carry out their duties.

Judgment: Substantially compliant

Regulation 23: Governance and management

The changes to governance and management structures and systems were starting to bed in and have a positive impact on residents' lived experiences. There were clearly defined lines of authority and accountability and staff had clearly defined roles and responsibilities. However, improvements was still required to ensure that audits were completed regularly and that oversight and management meetings continued to ensure that required improvements progressed in line with the centres' transition plan submitted to the Office of the Chief Inspector.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose contained all the information required by schedule 1 of the regulations and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had established systems to address and resolve complaints. There was a local complaints officer in place and complaints the procedure was on display throughout the centre. However, on reviewing a number of complaints, the inspectors found that it was unclear as to whether some complaints had been resolved to the satisfaction of the complainant. In others reviewed, it was recorded that the complainant was not satisfied and there was no evidence of further follow up to attempt to resolve the complaint.

Judgment: Not compliant

Quality and safety

The inspectors found that the provider was on a journey and in the process of bedding down change and that this was starting to have an impact on the quality of residents' care and support. The provider and person in charge were striving to ensure that the quality of the service provided for residents was good. There was a clear plan in place in relation to the future direction of the service which had been submitted to the Office of the Chief Inspector (OCI). This plan clearly outlined how the provider planned to move into compliance with the regulations and improve the quality of care and support for residents.

The inspectors found that additional efforts had been made to make the premises more homely, such as pictures and soft furnishings. However, concerns remained in relation to the suitability and fitness for purpose of the building. The building was not meeting the number and needs of residents or the requirements of schedule 6 of the regulations. In addition, improvements were required to the maintenance and cleanliness of one of the premises. The provider had submitted a full transition plan to the Office of the Chief Inspector (OCI) which set out the future plans for the service and outlined that this plan would be fully implemented by 31 October 2021. The provider described plans for one resident to transition from a multiple-occupancy bedroom to a single occupancy over the coming months and for

another resident to be supported to transition from the service in line with their wishes.

There was evidence of improved consultation with residents over the last number of months. Residents' meetings were continuing and there was evidence that actions following these meetings were improving the quality and safety of care for residents. A number of residents were acting as representatives on groups across the organisations such as the advocacy and the project group. Plans were in place for residents and staff to review the centres' residents' survey prior to the next annual review of care and support. One resident described their role on the advocacy group and how they were supporting their peers to raise their concerns as required. There was information available in both premises in relation to accessing advocacy services. Further improvements were noted since the last inspection in relation to residents' privacy and dignity due to works to place a partition wall in another multiple-occupancy bedroom. However, some residents' privacy and dignity were still not upheld due to the design and layout of the centre including multiple-occupancy bedrooms.

Overall, the inspectors found that improvements continued to be made in relation to meeting residents' social care needs. An external provider continued to support the provider to review and meet residents' assessed needs. They were providing social care workers to support residents to engage in meaningful activities in line with their needs and wishes. A number of residents and staff told the inspectors of the positive impact that the vehicle which was now available to support resident to access the community was having. Whilst the inspectors found that further improvements had been made in relation to residents' activity levels and access to the community, on reviewing a number of residents' activity records, it was evident that further improvements were required for some residents.

Improvements were noted in some residents' personal plans. There was evidence that personal plans were being reviewed to ensure they were effective and evidence of involvement of residents and their representatives in the development and review of residents' personal plans. There was evidence of the development and progression of goals for a number of residents. However, the inspectors reviewed a number of residents' goals which required review to identify why they were not progressing in a timely manner.

The inspectors found that each resident was not supported at all times to communicate in accordance with their needs and wishes. A number of residents' personal plans did not outline what interventions were required to support them to communicate. Sufficient guidance was not in place to guide staff to support residents. One resident required particular supports to communicate and this support was not available to them at all times. This was discussed with the management team during the inspection and plans were in place to review the arrangements to ensure the resident had access to support in line with their needs. A new computer dock had been put in place for residents to access the Internet since the last inspection.

Residents who required them had responsive behaviour support plans in place. The

inspectors reviewed these for a number of residents and found that they were detailed and guiding staff to support residents to manage their behaviour. They included proactive and reactive strategies. Risk assessments were developed in line with risks identified in these responsive behaviour packs. There was a restraints register in place and restrictive practices which were in place for safety, were reviewed regularly by the appropriate allied health professionals.

Safeguarding procedures had been further strengthened since the new designated officer was appointed. There had been an increase in the number of allegations of abuse since the last inspection including a number of allegations made by residents against staff members. This increase was due to the increased awareness of safeguarding in the centre and the improved safeguarding procedures which were now bedded in. There was evidence that each allegation was appropriately followed up on in line with national policy and the organisations' policy. The provider had recognised compatibility issues in relation to a number of residents and was holding a meeting with the appropriate professionals to review the suitability of their placement in the service. The provider outlined that residents would be supported to access a service appropriate to their needs if deemed necessary following this meeting.

Residents were protected by appropriate risk management policies, procedures and practices. There was a system for keeping residents safe while responding to emergencies. There was a risk register and risk assessments which was reviewed and updated regularly in line with incidents. Incident review and tracking was evident in residents' personal plans as was the learning following incidents.

Regulation 10: Communication

Not all residents were supported to communicate in line with their needs. Some residents' personal plans did not outline what supports residents required to communicate and required communication supports were not in place for all residents.

Judgment: Not compliant

Regulation 13: General welfare and development

Efforts were being made to support residents to partake in their local community. Improvements were noted in the level and variety of activities some residents were partaking in. However, some residents had limited opportunities to partake in education or to engage in activities in the community.

Judgment: Substantially compliant

Regulation 17: Premises

Improvements had been made to the premises to make it more homely. However, the design and layout of the premises was not meeting the number and needs of residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

Residents were protected by appropriate risk management policies, procedures and practices. General and individual risk assessments and the local risk register were reviewed regularly in line with learning following incidents.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Overall, residents' personal plans were found to be person-centred. Residents had an assessment of need and care plan in place in line with their identified need. They had access to a keyworker to support them to develop their goals. There was evidence that the majority of these were reviewed as necessary in line with residents' changing needs and to ensure they were effective. However, the inspectors reviewed a number of residents' goals which were not progressing in a timely manner.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents who required them had responsive behaviour support packs in place which contained risk assessments and outlined proactive and reactive strategies to support residents to manage their behaviour.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by safeguarding policies, procedures and practices. A number of previous safeguarding issues were managed appropriately. The provider had recognised compatibility issues between residents and were in the process of reviewing the suitability of placement for one of the residents. Appropriate measures were in place until this process was completed. 100% of staff had completed safeguarding training.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted with and participating in the planning and running of the designated centre. They had access to advocacy services if required. However, the inspectors found that improvement was required in relation to protecting residents' privacy and dignity due to the design and layout of the premises including multiple occupancy bedrooms.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cherry Orchard Hospital OSV-0003730

Inspection ID: MON-0025095

Date of inspection: 04/12/2018

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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: The process for recruiting a new CNM1 has commenced and is now with Human Resources.</p> <p>The vacant Health Care Assistant position has now been filled. The HCA commenced induction on the 07/01/19 and will be super-nummery in the designated centre for 2 weeks. This person will have received all mandatory training during this induction period, including safeguarding awareness training.</p> <p>The roster format will be reviewed by nursing administration to ensure its compliance with the regulations and the Statement of Purpose. This will be completed by 15/02/19</p> <p>An agency social worker (0.6 WTE) is being recruited currently to replace the person who left in November.</p> <p>All of the actions above will be completed by 31/03/19.</p>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff on both units in the designated centre are now 100% compliant with HSE Land Supervision Training.</p> <p>Education to additionally support and improve staff understanding of localized supervision documentation and appropriate application of the Supervisory process has also been developed and will be provided by the Education Officer on 18/01/19, 08/02/19, 13/02/19, 18/02/19 and 21/02/19. There will be both morning and afternoon sessions on these days allowing for further clarity and improvement for all staff members.</p>	

Supervision policy is underway and will be completed by 31/01/2019 to further guide staff.

14 RGN's have now received supervision from the Person in Charge to date. The Person in Charge is ensuring that all staff will have received at least one supervision session by 31/01/19.

100% of staff on both units are now up to date with their MAPA Training. The Education Officer is monitoring mandatory training dates and highlighting to managers when staff members are nearing their renewal dates to promote compliance and avoid lapses.

Responsive Behaviour training is being provided by cANP (Older Persons Integrated Care & Behaviour) on 08/01/19, 09/01/19, 10/01/19, 15/01/19, 22/01/19, 24/01/19, 25/01/19. This training will be provided on both mornings and afternoons on each day and will cover the following areas for staff; communication, risk, consent, open disclosure, NIMs, special 1:1 carers and documentation.

Dysphagia Training is also being provided by Speech and Language Therapy on 11/01/19, 18/01/19, 21/01/19, 29/01/19, 31/01/19, 01/02/19 and 04/02/19. This training will provide diet and fluid consistency training, strategies to optimise safety, promotion of person centred approach to mealtimes inclusive of residents wishes and preferences. This training will also be offered at regular intervals throughout the year by speech and language therapy.

Staff are being asked to complete Do the right thing: HSE Risk and incident management module on HSEland by 14/02/19. An Incident management and reporting workshop is also scheduled for 17 /01/19. This will be provided by the Quality and Risk Advisor.

All of the training identified above will be completed by 28/02/19.

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

The management team have reviewed the structures in place and can confirm:

Fortnightly assurance teleconferences are continuing and dates have been set for 2109.

Monthly management meeting dates have been set for 2019.

Monthly Project group meetings have been scheduled for 2019.

Supervision meetings between the PIC and PPIM have been set for 2109.

Supervision meetings between the provider nominee and PIC have been set for 2019.

Management walkabouts by the provider nominee and Quality & Risk Advisor have been set for 2019.

Quality & Risk meetings have been set for 2019.

Staff meetings in both units in the designated centre have been set for 2019.

The Education officer is compiling a database comprising of a schedule of audits for both units which will provide consistency of practice and tracking of required progression of quality improvement measures, this will be completed by 31/01/2019.

CNM1 is undertaking a Clinical Leadership course in May 2019.

Regulation 34: Complaints procedure

Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The complaints audit is being carried by the PPIM monthly and the outcome reviewed by PPIM and PIC every month.

All current complaints except one made by a respite client have resolved and closed. The PPIM will meet the respite on his next admission to discuss further about the progress of his complaint.

The complaint recording form is being amended to ensure compliance with the regulations.

These actions will be completed by 31/01/19.

2 of the PPIM's have been registered to attend a 2 day programme in After Action Review (AAR), which is a structured facilitated discussion of events which helps the individuals involved in an incident / event to identify what was expected to happen, what actually happened, to understand why the outcome was different, to identify what went well and what did not go as expected. This will improve and standardise how both incidents and complaints are dealt with across the site.

Regulation 10: Communication

Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication: Speech and language therapy input to the designated centre is provided from the overall service on the campus which is managed through primary care. Referrals are prioritised based on clinical need and risk in the context of the overall service delivery to the overall campus. Referrals are being sent to Speech and language therapist for the review of residents that requires communication support. However, due to resourcing issues these residents may take some time to be seen.

A business case is being prepared for additional dedicated speech and language therapy resources for the designated centre acknowledging the requirements of this service to support transition planning for residents.

Speech & Language Therapy are reviewing all cases currently open to them to ensure communication guidelines for staff are in place for residents with communication impairments

These actions will be completed by 31/03/19.

Regulation 13: General welfare and development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 13: General welfare and development:</p> <p>Personal Plans are being updated currently which will explore opportunities for all residents to access community resources and outings.</p> <p>Care plans are currently being updated and will be completed by the 31/01/19</p>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>The cleaning schedule for the centre is being reviewed.</p> <p>It is intended to close Lisbri as per condition of registration by 31/10/2021. In the meantime the HSE will continue to explore available options to create additional single rooms and continuing to make the centre more homely for residents.</p>	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>Personal Plans are being updated currently which will explore opportunities for all residents to access community resources and outings.</p> <p>Auditing personal plans will be carried out in 2019 using the national audit tool. This will ensure that the compliance with the regulations is met.</p> <p>These actions will be completed by 30/04/19.</p>	
Regulation 9: Residents' rights	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <p>It is intended to close Lisbri as per condition of registration by 31/10/2021. In the meantime the HSE will continue to explore available options to create additional single rooms and continuing to make the centre more homely for residents.</p> <p>Resident rights will be protected during the transition processes through meaningful consultation with residents and families, use of advocacy services and individualized approaches to transitions.</p> <p>Lisbri will be closed by 31/10/21 as per condition of registration.</p>	

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	31/03/2019
13 (2) (b)	Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/01/2019
13 (2) (c)	Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	31/01/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	15/02/2019
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of	Not Compliant	Orange	31/03/2019

	residents, it is provided.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	15/02/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	28/02/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2019
17 (1) (a)	Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/10/2021
17 (1) (c)	Provide premises which are clean and suitably decorated.	Not Compliant	Orange	31/03/2019
17 (7)	Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.	Not Compliant	Orange	31/10/2021
23 (1) (c)	Put management systems 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	31/05/2019
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/01/2019
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	Not Compliant	Orange	31/01/2019

	a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
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	30/04/2019
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/04/2019
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/10/2021