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

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| Name of designated centre: | Devon Lodge Services |
| Name of provider: | Ability West |
| Address of centre: | Galway |
| Type of inspection: | Announced |
| Date of inspection: | 29 October 2021 |
| Centre ID: | OSV-0001494 |
| Fieldwork ID: | MON-0026778 |

## About the designated centre

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

Devon Lodge provides services to adults with an intellectual disability who have been identified as requiring a support level ranging from minimum to high as per National Intellectual Disability Database classifications. It is intended to meet the needs of people whose primary diagnosis is intellectual disability and may also include co-morbidity. Devon Lodge Services provides a seven day residential placement for five male and female residents from the age of 18 upwards. The centre comprises of one house in a residential area by the sea on the outskirts of a city, and has good access to the a wide range of facilities and amenities. Residents at Devon Lodge are supported by a staff team that includes; a team leader, social care workers and care assistants. Staff are based in the centre when residents are present including at night.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 5 |

## 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 |
|---|---|---|---|
| Friday 29 October 2021 | 09:20hrs to 14:30hrs | Catherine Glynn | Lead |

## What residents told us and what inspectors observed

The governance and management arrangements required review as they were not effective in ensuring this service was safe or appropriate in meeting the assessed needs of the residents. The inspector found that while the service was adequately resourced, issues with the compatibility of residents. Two residents spoken with, discussed the challenges of the behaviour of another resident, and the impact this was having on them. This included not being able to access communal areas of the house, and the risk of negative interactions or threat of aggression.

The inspector met with five residents and spoke with five residents as part of this inspection. While the residents were receiving support from staff, there were times when one resident required more support due to their behaviours. There was ongoing compatibility issues between residents in the centre, which resulted in the delivery of ineffective, inconsistent and unsafe services to some of the residents. Staff were aware of the issues identified but felt they were redirecting these behaviours, however, they failed to recognise the impact of this environment on some of the residents. As a result of these behavioural issues, residents reported that restrictions were in place as they were unable to access facilities, or rooms due to the risk of a negative interaction or threat of physical injury. Furthermore, residents openly admitted that they avoided contact with the resident experiencing the mental health issues.

Staff were observed and overheard being respectful and courteous to the residents over the course of the inspection and residents appeared relaxed in the company of staff in certain areas of the centre. Staff were also observed to be respectful of the communication preferences of residents. In addition, the staff and person in charge had ensured that information relevant to the residents was displayed in the hallway of the centre.

There were five residents living in this centre and the inspector met briefly with all five residents during the morning. One resident expressed unhappiness with the their current placement. They had spoken with the provider and their representatives and had been advised that a change of service may happen but cannot be facilitated at present. Two other residents both clearly stated they were uncomfortable with another residents behaviours. As a result they found that there was limitations on their living environment and unintended restrictions as a result. Furthermore, these residents were also aware of the providers suggestion that a change could happen in the service but there was no time-bound plan in place for the completion of this review. All the residents had recently re-engaged with their day services and were enjoying the activities and social aspect of this service, and in-particular the break away from the centre. Residents bedrooms were comfortable and nicely decorated and had a number of personal pictures on display. There was sufficient bathroom facilities available in the centre. All the residents reported that they could talk with their staff and the person in charge if they had any worries.

Staff spoken with in this house were observed to be kind and respectful in their interactions with residents; however staff spoken with recognised and had highlighted the incompatibility of the residents and described the environment as tense at times which did not promote a homelike environment. Staff spoke about measures they took to promote safeguarding practices in the centre but this had resulted in limitation on residents accessing communal areas of their home.

From a walk around of the centre, there were small areas that required improvement. The carpet on the stairs in the hallway was worn, frayed and discoloured, the armchair in the back sitting room required repair. Overall, the centre was homely, suitably decorated and reflected residents personal choices and preferences.

The next two sections of the 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

Overall, the provider was able to demonstrate that they had good systems in place for the person centred needs and support. However, some area's required improvement, such as notifications, and the effective oversight or response to compatibility issues, in the centre.

There were sufficient staff on duty on the day of the inspection in order to meet and support the needs of the residents. These staff were employed on a regular basis by the provider and had developed good relationships with the residents. The inspector observed warm and engaging interactions between residents and staff and it was clear that the relationships were mutually respectful and beneficial to the residents and staff members supporting them. Residents told the inspector that the staff were very busy with documentation and they felt this was unnecessary. The provider had a clear roster in place, which ensured that there were sufficient staff on duty at all times. Where necessary, staff provided overnight cover on a sleeping or waking night basis, as residents needs required. The provider was able to demonstrate good practice in relation to the recruitment of staff by ensuring that all required pre-employment clearances had been completed for staff working in the centre, including evidence of current Garda Vetting clearances.

Staff training records demonstrated that the provider had continued to ensure that staff were receiving regular training and refresher training, with an emphasis on mandatory training, and training in infection control practices as required. The provider had also provided bespoke training to ensure staff were supported to meet the needs of all residents in the centre. This included, autism, communication, first

aid and dementia awareness. Additional training in various aspects of infection control had also been provided to staff in response to the COVID-19 pandemic.

In the majority of documentation reviewed, the inspector noted that there was generally good provider led oversight in place. For example, the risk register and health and safety documentation in the centre was being kept up-to-date and were relevant and clear. The inspector reviewed both the annual review and the most recent six-monthly unannounced visit report and found that these were clear and balanced and had identified some areas where action was required to ensure a good quality service was being offered. The provider had not demonstrated a satisfactory, time-bound response to address issues in the centre in a timely manner, and they had not recognised that notifications were not being submitted to the chief inspector as required by the regulations.

The provider had developed a comprehensive contingency plan to reduce the risk of COVID-19 entering the centre, and for the management infection should it occur. Furthermore, the centre was suitably resourced to ensure effective delivery of care and support to residents.

Records viewed during the inspection, such as staff training records, personal plans, COVID-19 and infection control, were comprehensive, informative and up-to-date. There was an informative statement of purpose which gave clear description of the service and met the requirements of the regulations.

There was an effective complaints procedure that was accessible to residents. The inspector reviewed the centre's complaints log and noted that there were systems to respond to complaints in a prompt manner.

Overall, the improvements were required to address the oversight of the service and the submitting of notifications to the chief inspector as required by the regulation.

## Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and included the information set out in schedule 1.

Judgment: Compliant

## Regulation 14: Persons in charge

There was a full-time person in charge employed in the centre. The person in

charge had the required management experience and qualifications. The inspector found the person in charge knowledgeable on the residents' needs and on their individual support requirements.

Judgment: Compliant

## Regulation 15: Staffing

Staff levels and skill-mixes were sufficient to meet the assessed needs of residents at the time of inspection. Planned staffing rosters had been developed by the management team and these were accurate at the time of inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

All staff who had worked in the centre had received mandatory training in fire safety, behaviour support, manual handling and safeguarding, in addition to other training relevant to their roles.

Judgment: Compliant

## Regulation 19: Directory of residents

The provider had established and maintained a directory of residents in the centre. The inspector found that it contained all required information as specified by the regulations.

Judgment: Compliant

## Regulation 22: Insurance

The provider had ensured that a contract of insurance against injury was in place in the centre and was in-date as required.

Judgment: Compliant

## Regulation 23: Governance and management

While there was a good management structure in place. improvements were required in the auditing and oversight by the management team to ensure that areas for improvement were identified and addressed in a timely manner.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

There was a statement of purpose which described the service being provided to residents and met the requirements of the regulations.

Judgment: Compliant

## Regulation 31: Notification of incidents

The provider had not ensured that adverse events as listed in the regulations that occurred, such as any allegation of suspected or confirmed abuse, were reported to the chief inspector in the required period.

Judgment: Not compliant

## Quality and safety

Residents were being supported to have a meaningful life but improvement was required as there was ongoing compatibility issues between residents, within the centre. This resulted in an unsafe service for some of the residents and limitations on accessing communal areas of the centre.Although the provider was aware of the issues, they had not taken appropriate actions to address these concerns. Improvements were also required to the management of positive behaviour support for one of the residents, and the premises.

The provider had systems in place to safeguard the residents, however, improvement was required due to the compatibility of residents living in the centre. While the residents reported peer-on-peer related issues, they were not being recorded or reported as required but they were being responded to by staff.

Residents informed the inspector that they avoided contact with one resident where possible, had allowed one communal room to be utilised by this resident only, did not engage in conversation or interaction where possible and they reported they had negative experiences. The staff and person in charge were aware of these practices and promoted the methods being utilised, so as to avoid any escalation of behaviours within the house. In addition, staff had failed to record or report these behaviours as they felt it was unnecessary and were able to manage through redirection or limiting the residents from communal areas in the centre. During the inspection, the inspector spoke with the person in charge and person participating in management, they were ware of the compatibility issues. The issues were highlighted but had not been successful at the time of the inspection as the provider had failed to respond appropriately.

Residents were supported with their healthcare needs as required and had access to general practitioner (GP) services as required. The inspector saw that residents had annual medical reviews completed and had as required access to allied health professionals such as dentist and chiropodist. Care plans were also in place to guide staff in supporting residents to achieve best possible health.

While the provider had a policy and procedure in relation to managing positive behaviour support and staff were trained as required, residents were not supported to enjoy the best possible emotional health and well being. On review of a sample of residents' files, the inspector noted that one resident who had mental health issues and required behavioral support, had not been reviewed since November 2019. As a result ,while there was a recognition of a deterioration in the residents' mental health, on-going behavioural issues, and no updated guidance for staff to follow. This resulted in negative outcomes for all residents in their living environment in the centre.

The inspector reviewed the premises, and found that the centre for the most part was clean, although some areas required review. This included, the worn, badly fitting carpet in the hallway, and review of a damaged armchair in the back sitting room. The inspector noted that the centre was suitably decorated throughout, comfortable, spacious and well laid out. The person in charge had highlighted the areas for improvement was was still awaiting completion of these tasks at the time of the inspection.

There were systems in place to manage and mitigate risk in the centre. There was a policy on risk management available and each resident had a number of individual risk assessments on file so as to support their overall safety and wellbeing. Adverse incidents had not been reported and were not recorded appropriately, therefore, follow-up actions were not implemented.

Overall, while the feedback from residents and family was positive, some of the residents were not happy in their home and at the time of the inspection there were no actions in place to address these concerns for the residents.

## Regulation 10: Communication

Residents were supported to communicate in their preferred manner and had communication plans in place, with pictorial images and easy read documents to assist them where necessary. They also had access to technology and their own phones to stay in touch. It was apparent from observation that the staff and the residents communicated easily and warmly.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents were supported to take part in a range of social and developmental activities both at the centre, and in their community. Suitable support was provided to residents to achieve this in accordance with their individual choices and interests, as well as their assessed needs.

Judgment: Compliant

## Regulation 17: Premises

The centre comprised of one building located in a large town. On review of this service the inspector noted that while the centre met most of the requirements of schedule 6, improvement was required. This included, replacement of the carpet on the stairs in the hallway, the carpet was worn, damaged and marked, one armchair in the back living area, had damage on one cushion.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

There were arrangements for the control and management of key risks in the centre, which were recorded on a risk register. These were kept under regular review.However, improvement was required There was evidence that residents were also supported in positive risk making practices, including going to the local shops.

Judgment: Compliant

## Regulation 27: Protection against infection

There were robust measures in place to control the risk of COVID-19 infection in the centre.

Judgment: Compliant

## Regulation 28: Fire precautions

The provider had ensured that effective measures were in place to protect the residents and staff from the risk of fire.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Comprehensive assessments of residents' health, personal and social care needs had been carried out, and an individualised plan had been developed based on these assessed needs.

Judgment: Compliant

## Regulation 6: Health care

The health needs of the residents were assessed and supported in the centre. The residents also had good access to a range of healthcare supports, such as general practitioner and healthcare professionals.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Residents who required support with behaviours of concern had comprehensive support plans in place, however, the inspector found that one residents' behaviour support plan had not been reviewed by relevant members of the multidisciplinary team since November 2018. This did not promote good practice in relation to this

residents care and support needs.

Judgment: Substantially compliant

## Regulation 8: Protection

The safeguarding of residents required review in this service. The provider had failed to address the compatibility of residents in the centre.The inspector met five residents and two spoke of their worry, concern, avoiding contact with the resident experiencing unstable mental health and the limitations this had on their living environment. While the provider had responded to all residents advising that they would move this resident at some stage, this did not provide assurance to the residents or staff working in this facility.Two residents clearly stated that they were avoiding conversation or contact with this resident due to the risk of threatening and physical behaviours.

Judgment: Not compliant

## Regulation 9: Residents' rights

The provider had not ensured that the resident's rights were supported and that they had the freedom to exercise choice and control in their daily life.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Registration Regulation 5: Application for registration or renewal of registration | Compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Devon Lodge Services OSV-0001494

## Inspection ID: MON-0026778

## Date of inspection: 29/10/2021

**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 23: Governance and management | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A comprehensive auditing process has been implemented following a meeting with the Person in Charge and the Person Participating in Management on the 18/11/2021. This will incorporate an overall review of care and support needs of all residents and will include ongoing review of safeguarding and compatibility within the service, environmental reviews within the service, health care reviews, behaviour support and psychological supports and overall assessment of needs.
Any actions identified in these reviews will be followed up by the Person in Charge in a timely manner and escalated if required.

An environmental review was carried out on 18/11/2021 which identified a restriction in place for residents in this service. This will be referred to the Human rights committee and on the agenda for the their next meeting on 14/12/2021, this restriction will be included in the quarterly returns for submission to HIQA for quarter 4 of 2021 as required by the regulations.

The following audits are also completed by the Person in Charge on a regular basis, e.g. medication, finance, training, rosters, health and safety checks, risk assessments and a review of incidents. Following on from the HIQA inspection, the Person in Charge will undertake a review of incidents on a weekly basis and action accordingly.

Provider led audits continue to take place six monthly and any actions identified will be followed up on and completed in a timely manner.

The Person in Charge and the Person Participating in Management will continue to meet on a monthly basis and agenda items for these meetings will include oversight of governance and management, risk management, safeguarding and compatibility, responding to behaviours that challenge, management of notifications and health care

needs.

| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A full safeguarding review took place in Devon Services with the Person in Charge and the residents on 16/11/2021. As a result of same, new safeguarding plans were completed by the Designated officer for two residents and an existing safeguarding plan for one resident was updated. NF06 notifications were submitted to HIQA on 19/11/2021 to reflect same.

An environmental review was carried out on 18/11/2021 which identified a restriction in place for residents in this service. This will be referred to the Human rights committee and on the agenda for their next meeting on 14/12/2021, this restriction will be included in the quarterly returns for submission to HIQA for quarter 4 of 2021 as required by the regulations

All notifications to HIQA will be submitted in a timely manner going forward and the Person in Charge will undertake a weekly review of incidents.

| Regulation 17: Premises | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:
The carpet on the hallway will be replaced by 01/12/2021.
The couch in the back living area was replaced on 01/11/2021.

| Regulation 7: Positive behavioural support | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The psychological guidelines in place for one resident are currently being reviewed and updated by the Head of Psychology. This will be completed by 01/12/2021.

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| Regulation 8: Protection | Not Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
A full safeguarding review took place in this service with the Person in Charge and the residents on 01/11/2021. The residents were given the opportunity at this meeting to discuss their concerns with the Designated Officer and strategies were agreed with them to manage difficult situations within the service. These strategies are included in new safeguarding plans, completed by the Designated Officer on 19/11/2021, for two residents and an existing safeguarding plan for one resident.

These safeguarding plans will be reviewed and discussed at a staff meeting on 09/12/2021 and will be kept under regular review.

A further safeguarding strategy meeting to discuss safeguarding and compatibility concerns is scheduled for 07/12/2021 and in attendance at this meeting will be the Designated Officer, PIC, PPIM, Head of Psychology and another member of the psychology department.

The Designated Officer will attend a further meeting with residents in December where further reassurance will be provided to the residents. This will take place on 16/12/2021.

In relation to one resident with mental health needs, an emergency psychiatric review took place following the HIQA inspection on 01/11/2021. It was agreed that this resident will be reviewed more regularly and on an urgent basis if needed and medication will be kept under close review.

In relation to this resident's wishes to move out of his current service and also due to compatibility issues, a discussion took place at the residential review meeting on 04/11/2021 and alternative options explored for this resident.

It is hoped that an alternative living arrangement for this resident will be completed within 4- 6 months.

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| Regulation 9: Residents' rights | Not Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A full safeguarding review took place in this service with the Person in Charge and the residents on 16/11/2021. The residents were given the opportunity at this meeting to

discuss their concerns with the Designated Officer and strategies were agreed with them to manage difficult situations within the service. These strategies are included in new safeguarding plans, completed by the Designated officer on 19/11/2021, for two residents and an existing safeguarding plan for one resident. These safeguarding plans will be reviewed and discussed at a staff meeting on 09/12/2021 and will be kept under regular review.

A further safeguarding strategy meeting to discuss safeguarding and compatibility concerns is scheduled for 07/12/2021 and in attendance at this meeting with will be the Designated Officer, PIC, PPIM, Head of Psychology and another member of the psychology department.

The Designated Officer will attend a further meeting with residents in December where further reassurance will be provided to the residents. This will be completed on 16/12/2021.

In relation to one resident with mental health needs, an emergency psychiatric review took place following the HIQA inspection on 01/11/2021. It was agreed that this resident will be reviewed more regularly and on an urgent basis if needed and medication will be kept under close review.

In relation to this resident's wishes to move out of his current service and also due to compatibility issues, a discussion took place at the residential review meeting on 04/11/2021 and alternative options explored for this resident. It is hoped that an alternative living arrangement for this resident will be completed within 4- 6 months.

## 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 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 | 01/12/2021 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Substantially Compliant | Yellow | 31/12/2021 |
| Regulation 31(1)(f) | The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse | Not Compliant | Orange | 19/11/2021 |

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| | incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident. | | | |
| Regulation 07(3) | The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process. | Substantially Compliant | Yellow | 01/12/2021 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 16/11/2021 |
| Regulation 09(2)(b) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life. | Not Compliant | Orange | 16/11/2021 |