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:	Hall Lodge
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	17 and 18 July 2023
Centre ID:	OSV-0001709
Fieldwork ID:	MON-0039699

About the designated centre

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

Hall Lodge is a designated centre operated by Sunbeam House Services CLG. The centre is located in a campus based setting near a town in South East Wicklow. Hall Lodge provides residential care and respite for up to four adults with intellectual disabilities with associated medical and physical support needs. The centre comprises one large property which provides residents with single occupancy bedrooms, a kitchen, communal space living room areas, staff office, staff sleep over arrangements, bathroom and toilet facilities. The centre is managed by a person in charge who reports to a senior services manager.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 17 July 2023	20:15hrs to 21:45hrs	Michael Muldowney	Lead
Tuesday 18 July 2023	09:10hrs to 18:10hrs	Michael Muldowney	Lead
Tuesday 18 July 2023	09:10hrs to 18:10hrs	Jennifer Deasy	Support

What residents told us and what inspectors observed

This unannounced inspection took place over two days. It was carried out for the purposes of the ongoing regulatory monitoring of the centre, to assess the provider's progress in implementing improvements to the centre since the previous inspections in December 2022 and January 2023 which both found poor levels of compliance across a number of regulations.

The inspection was also carried out in response to unsolicited information received by the Chief Inspector of Social Services in July 2023 regarding concerns about the quality and safety of service provided to residents in the centre.

Overall, inspectors found that the provider had failed to fully address areas of non-compliance with regulations and had not ensured that residents were in receipt of a good quality and safe service.

The centre was registered to accommodate a maximum of four residents. There were two-full time residents living in the centre with capacity for two respite users. Respite services had been suspended since the beginning of the COVID-19 pandemic. Inspectors were informed that the provider was not planning on resuming respite services until the known issues with the premises had been resolved.

The premises comprised of a large main building accommodating one resident and an adjoining self-contained apartment accommodating the other resident. Inspectors carried out an observational walk around of the centre with the deputy manager.

The main building, intended as a respite service, comprised four resident bedrooms (some with en-suite facilities), staff bedroom, staff room, office, medication room, large catering-style kitchen, boiler room, storage room, three large walk-in store areas, two sitting rooms, utility area, small toilet, two large bathrooms (one of which was not in use at the time of the inspection due to outstanding repairs), and large open plan main living area. There was one resident living in this main house and their bedroom was located at the end of the building and shared a wall with the bedroom in the apartment. The deputy manager told inspectors that there were plans to renovate the bedroom including painting of the room, however there was no date for the completion of these works.

While the large spaces in the building were effective in allowing for increased autonomy in physical movement throughout the centre for the resident, it was not conducive to creating a homely and personalised living environment, and the resident was seen to mainly access one living room on the day of inspection. There was a strong smell of disinfectant cleaning chemicals in the building which had been used as part of the routine cleaning of the floor. This contributed to an institutional presentation in the centre.

Inspectors observed a visual staff rota in the hallway showing staff working in the centre. In the main living room, there were balloons and decorations from the resident's recent birthday. There was also a large notice board in the medication room that was used to plan the resident's weekly social activities. The board had hand written text and reflected limited activities including lunch in the local shopping centre, massage therapy and a home visit. Some days were left blank and most days detailed only one activity. Inspectors spoke with staff about the planner, and they upon discussion, agreed that it was not physically accessible to the resident in the medication room, and furthermore it was not displayed in a format that the resident could understand. Staff told inspectors that the resident could understand pictures, and showed them a sample of pictures used to support the resident to choose their meals.

The adjoining apartment comprised of a bedroom with en-suite bathroom, staff office with en-suite bathroom, kitchen/dining room and sitting room. Since the previous inspection, part of the apartment had been renovated, including repainting and repairs to a hole in the kitchen. Inspectors observed that parts of the apartment required cleaning. Inspectors also noted a smell of cigarette smoke in the kitchen and observed discarded cigarette butts outside the apartment. These matters are discussed further in the quality and safety section of the report.

As noted in previous inspection reports, overall the premises presented an institutional aesthetic due to the layout and size of the building. Some efforts had been made to make the building more homely and comfortable, such as painting and display of pictures. The provider had previously planned to renovate and reconfigure the centre to better meet the needs of the residents, however these works had not materialised. The premises are discussed in more detail in the quality and safety section of the report.

Inspectors observed several restrictive practices during their walk around of the premises, including practices which had not been self-identified by the provider as restrictions. Inspectors found that the provider's oversight and management of restrictive practices did not demonstrate that residents' rights were been upheld in some of these areas. Inspector observed some improvements had been made to the fire safety systems and infection prevention and control (IPC) measures in the centre, however there were still deficits that required attention. Overall, the observations and findings of the inspection in relation to fire safety, IPC, and restrictive practices demonstrated that the provider did not have adequate oversight and management systems to self-identify and address deficits in the quality and safety of the service.

Inspectors met one of the resident on both days of the inspection. They were observed to be content and relaxed in their home. They did not communicate their views on the service provided in the centre, but did engage with the inspectors through gestures, eye contact, and some words. They spoke about visiting their family and their recent birthday. Staff were observed engaging with the resident in a warm and kind manner, and they appeared to have a good rapport. On the first evening, the resident was watching a movie in the main living area. On the second day, they were supported by staff to have their lunch out in a local shopping centre,

go to the cinema, and have a hair cut in the barbers. They were accessing their community through the use of taxis. Inspectors were told that this resident had their own car, however it was not in use for approximately three weeks due to a lack of clarity regarding its insurance. This matter is discussed further in the capacity and capability section of the report.

The other resident living in the centre was in bed when the inspector called to the apartment at approximately 8.15pm on the first evening, and were out with staff for most of the second day of the inspection. Inspectors briefly met them, however they did not communicate their views. Staff told the inspector that the resident usually chose to go to bed around 7.30pm-8.30pm, and communicated this by leading staff to their bedroom.

Inspectors did not have the opportunity to meet residents' representatives. However, the management team told inspectors, that some representatives had made complaints regarding the service, and had requested a meeting regarding their concerns which the person in charge and senior services manager were planning to arrange.

Inspectors spoke with several staff during the inspection including the person in charge, deputy manager, senior services manager, behaviour support practitioner, and social care staff.

The person in charge and deputy manager commenced in their roles since the previous inspection of the centre in January 2023. They told inspectors about some of the improvements since then, such as enhancement of the staff-skill mix and a consistent staff team who provided good care and support, and implementation of behaviour support plans which were leading to reduction in incidents of concern. They told inspectors about some of the activities residents enjoyed, such as social clubs and visiting family, and about how some residents were supported to engage in new meaningful activities such as attending local community celebrations and parades. The person in charge expressed concerns that the centre was not appropriate for meeting all residents' needs, for example, the size of the main building was big and not conducive to a homely environment, and some residents' needs were complex requiring specialist input and support which was considered to be outside of the provider's resources.

The senior service manager told inspectors about the provider's engagements with their funder regarding the centre and some of the alternative living arrangements discussed. However, there was still no plan determined for the residents' long-term accommodation needs.

Inspectors spoke with three social care staff during the inspection. They told inspectors that noise travelling between the main house and apartment could disrupt both residents, and therefore the resident and staff in the main building were required to very quiet when the resident was going to bed. Some staff were concerned that this arrangement was impacting on the resident being able to freely use their home. On the first evening of the inspection, the deputy manager requested that the inspector be quiet when showing them around the main house at

approx 8.30pm. On the second day, while inspectors were in the apartment they could clearly hear staff and the other resident in the main house conversing at normal sound levels. The person in charge told inspectors that there were plans to install padding in the resident's bedroom in the main building to reduce sound travelling, however there was no time frame for this.

Overall, staff told inspectors that aspects of the care and support provided to residents was good, however improvements were required. Some staff told inspectors that staff were limited in their ability to meet all residents' needs. Staff told inspectors that the person in charge was very approachable and responsive to their concerns.

Staff told inspectors that incidents of behaviours of concern had reduced since the previous inspection, and they were aware of the emergency procedures. However, some staff said that the protocol for managing serious behaviours of concern were not always effective. For example, the protocol detailed that staff should contact an out of hours' general practitioner service, however the service did not usually visit the centre and ambulance services were employed instead. The inspector also noted that the arrangements for contacting the provider's on-call system required more review, and this matter is discussed further in the report. Some staff also felt that the guidance for responding to head injuries was not adequate. Some staff told the inspector that they felt vulnerable working in the apartment at night and were concerned that the arrangement of relying on staff in the main building during an incident of concern posed a risk to the resident in the main building which had not been addressed. This concern is discussed further in the report. Staff were aware of how to safely evacuate residents in the event of a fire.

From what they were told, read, and observed during the inspection, the inspectors found that overall, there remained significant deficits in the quality and safety of service provided to residents in the centre due to the provider's failure to address areas requiring improvement and effectively monitor the service. The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

Inspectors found that the provider's governance and management systems and arrangements were not effective to ensure that the service provided to residents in the centre was safe, consistent or appropriate to their needs. While there were improvements under two regulations, overall this inspection found similar findings to previous inspections, with high levels of non-compliance attributable to the ineffective resourcing arrangements of the provider, for example, the resources available to address premise issues were not sufficient, and poor oversight of the care and support provided to residents in the centre.

This inspection also found additional examples of non compliance since the previous inspection in regard to regulations previously not inspected. This did not demonstrate that the provider's own monitoring and management of the service were responsive or effective as they had failed to self identify these issues.

While the provider had prepared written agreements on the terms that the residents would reside in the centre, they were not detailed to clearly outline the services to be provided and the fees to be charged. Inspectors also found that the contracts of care had not been signed by the relevant parties to indicate their agreement.

In addition, there was a lack of clarity on the fees to be paid by a resident on the running of a vehicle belonging to them. Inspectors were told that one resident had purchased a vehicle. Staff drove this vehicle to support the resident to engage in community activities and healthcare appointments. There was a lack of clarity and detail regarding who was responsible for the maintenance and running costs of this vehicle. Furthermore, inspectors were informed that the vehicle had not been in use for approximately three weeks as the insurance status of the vehicle could not be clarified.

Overall, it was found the provider did not maintain suitable evidence or records to confirm if the vehicle had been adequately insured for previous years. In addition, assurances were not provided to inspectors on this matter during the course of the inspection or in the following days as requested by the inspectors. This lack of oversight from the provider and inability to provide assurances on this matter showed deficits in the provider's governance and management systems.

The person in charge had improved the maintenance of the planned and actual staff rotas, and the rotas viewed by inspectors showed the staff working in the centre. The Schedule 2 documents were not maintained in the centre or within close proximity of the centre, and inspectors were told that they could not be made available in the centre. Therefore, inspectors did not have the opportunity to review them.

The provider had enhanced the staffing skill-mix and complement to better meet the assessed needs of the residents. Since the previous inspection, there was new person in charge, and the vacant posts had been filled including the deputy manager post. The full staff team had reduced the need for agency staff and was promoting a better consistency of care for residents. The skill-mix had also been enhanced with a full-time positive behaviour support practitioner who inspectors were told was a positive addition to the team.

However, the night-time staffing arrangements required review by the management team to ensure they were sufficient to deliver a safe service for residents. Additionally, while there were enhanced local management arrangements, inspectors found that local managers were not familiar with the provider's policies and this was leading to inconsistencies in staff practices.

The arrangements for ensuring that staff had access to and were completing appropriate training as part of their continuous professional development had improved. Inspectors found that staffing training records were better maintained,

and showed that most had completed required training, however there was some deficits which posed a risk to the quality and safety of care and support provided to residents.

There were arrangements for staff to raise concerns about the quality and safety of care and support provided to residents. Staff told the inspector that they were comfortable raising concerns with the person in charge. Outside of normal working hours, staff could utilise an on-call system however, as noted in the quality and safety section of the report, deficits were observed in this system.

Regulation 15: Staffing

Since the previous inspection, the provider had filled staffing vacancies and the centre was now operating with a full staff complement which had resolved a reliance on agency staff and resulting in a better consistency of care for residents. The skill-mix of nurses and social care staff had also been enhanced with the addition of a full-time behaviour support practitioner.

However, some staff expressed concerns to inspectors regarding the night-time staffing arrangements. There was one waking staff in the apartment, and one sleeping staff in the main building. However, occasionally staff in the main building were required to leave the main building for short periods of time to support staff in the apartment manage behavioural incidents. Staff were concerned that this arrangement posed a potential risk to the safety of the resident in the main building and had escalated their concerns to the management team for consideration. Inspectors found that the arrangement had not been subject to a risk assessment, however the person in charge and senior services manager told inspectors that they were planning to review the arrangement.

Inspectors found that the maintenance of planned and actual staff rotas had improved since the previous inspection, as the sample of rotas viewed by inspectors clearly showed the staff working in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors found that the maintenance of staff training records had improved since the previous inspection. The training records viewed by inspectors were up to date and showed that staff were required to complete training in a range of areas including fire safety, managing behaviours of concern, infection prevention and control, first aid, safeguarding of residents, medication management, and supporting residents' dietary needs.

Most staff were up to date with their training however, some was outstanding.

For example, training in emergency first aid and managing behaviours of concern.

The person in charge had scheduled some of the outstanding training however, the outstanding deficits posed a risk to the quality and safety of care and support provided to residents in the centre as these areas of training related to known personal risks that residents required staff intervention and support.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured that the centre was resourced, managed,or monitored to ensure the effective delivery of care and support to residents. Several regulations were found to be not compliant in part due to the provider's failure to provide sufficient resources and implement effective monitoring systems.

The designated centre had previously operated as a respite centre with two permanent residents. The inspectors were informed that the provider was considering recommencing respite services however they were aware that this would impact on the living arrangements of the current residents. The provider outlined that they were in discussion with their funder regarding the model of care to be provided and had discussed the potential for alternative living arrangements. However, at the time of inspection, there was no clear, time-bound plan in this regard.

There was a range of audits in place, such as annual reviews, unannounced visit reports, health and safety audits, infection audits, to monitor the quality and safety of the service. However, the provider's oversight systems were found to be ineffective, as demonstrated in the recurrent poor inspection findings and additional areas of non compliance since the previous inspection that should have been self-identified and addressed by the provider. The provider's learning from previous inspections also required improvement, for example, issues related to infection prevention and control had not been effectively mitigated. There was also a failure to assess and manage known risks in the centre such as night-time staffing arrangements, and infection hazards.

Deficits in the provider's management systems were also found in relation to their oversight of resources. It had been recently identified by the provider that a vehicle owned by one resident was not covered by the provider’s insurance policy. While this vehicle had been temporarily grounded as a result, it had been in use and was driven by staff in the centre for some years prior to this. The provider could not give assurances on the day of inspection that the vehicle had been adequately insured during those years. The provider was given three additional working days to provide this information to the Chief Inspector, however was unable to provide clarity on

this matter.

The provider's management of the centre required improvement. Local managers were not familiar with aspects of the provider's policies, for example, fire. Managers spoke about being informed about 'the way things are done' verbally by others as opposed to having documented procedures to follow. For example, managers were unclear regarding the provider's policies on staff smoking arrangements and the frequency of fire drills. Managers informed inspectors that they were verbally told what these arrangements were rather than being directed to a particular policy. As noted earlier in the report, the deputy manager and staff told the inspectors that staff and the resident in the main building were required to be quiet and considerate of noise when the resident was going to bed to not disturb the other resident. However, the senior services manager told inspectors that noise could be made. This conflicting information did not demonstrate consistent management of the centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had prepared written agreements on the terms on which the residents would reside in the centre. Inspectors found deficits in both residents' agreements.

The first agreement, dated June 2021, was signed by the previous person in charge, and was not signed by the resident or their representative to indicate their agreement.

The second agreement was not dated or signed by any party, and did not detail the fees to be charged and the expenses for which the resident was responsible. In particular, there was a lack of clarity on the arrangements for the ongoing costs of maintaining and running a vehicle owned by the resident. The agreement noted "you have your own car for your designated use", but provided no further detail, and inspectors were given conflicting verbal information during the inspection regarding who was responsible for paying for the maintenance of the vehicle.

Inspectors also found that the resident who owned the vehicle, on one occasion, was required to pay for the car parking fees for a hospital appointment. However, other residents were not routinely responsible for paying car parking fees. The inspectors were informed verbally that the resident was required to pay these as they owned the vehicle however, this was not detailed in the agreement or any other document made available to inspectors.

Judgment: Not compliant

Quality and safety

The inspectors found that the quality and safety of the service provided in the centre to residents was significantly compromised due to deficits and risks in relation to fire safety, infection prevention and control (IPC) measures, premises, rights, restrictive practices, risk management, and the assessment and meeting of residents' full needs.

The inspectors found that the provider's systems for assessing, reviewing and managing risk required improvement. Some of the control measures outlined in risk assessments were not in place and required updating. The provider's system for responding to emergencies also required more consideration from the provider to ensure that it was effective.

The centre was located on the provider's campus. It accommodated one resident in a self-contained apartment, and one resident in the main building that was intended for providing respite services. Some upgrades had been carried out since the previous inspection such as painting, display of pictures, new furniture, and filling of a hole in the apartment. However, overall the premises required upkeep and renovation throughout. Parts of the centre had been nicely decorated, however, aspects remained institutional in aesthetic due to the size and layout of the building.

The provider's previous plan for the renovation and reconfiguration of the centre had not been achieved. The provider informed the inspectors that they were engaging with their funder to explore alternative options, such as alternative living arrangements and services from other providers, however there was no time frame or agreed plan to address premises issues and residents' living environments.

There was fire detection, fighting and containment equipment through the centre, and servicing records indicated that the fire extinguishers and blankets and were up to date. Since the previous inspection, some of the fire doors had been upgraded to enhance the fire containment measures. However, inspectors observed that some doors did not close fully when released, and the hinges on the self-closing device on one door had detached. The glass above the staff room in the apartment was also broken, but was replaced during the inspection.

Inspectors noted that the fire evacuation plan for the centre and a resident's individual fire evacuation plan required revision to ensure that they were accurate. While fire drills took place, there was a requirement for clarity regarding the carrying out of drills.

There was dedicated cleaning staff in the main building, and nursing and care staff also completed cleaning duties in addition to their primary roles. Generally, the centre was clean, and the provider had implemented some good IPC measures, however overall the measures were inadequate. The COVID-19 management plan required revision regarding the staff redeployment arrangements. Poor practices and arrangements were observed in relation to the management of soiled laundry, bodily

fluid spills, measures to reduce infection cross contamination, and access to hand sanitiser.

While residents' care and support needs had been assessed, the inspectors found deficits in the completion of the assessments. Staff spoken with told the inspectors that they had concerns on the effectiveness of the arrangements in place to meet residents' assessed needs. These concerns had also been noted in recent assessments carried out by the provider's multidisciplinary team.

The provider had not ensured that not all restrictive practices were being applied in line with their policy or evidence based practice. Some restrictions had been implemented without consent from the resident or their representative or the provider's committee for overseeing restrictions. Inspectors also found that the rationale for some restrictive procedures were not clear to demonstrate that they were the least restrictive options. A restrictive practice log, last reviewed February 2023, required updating and was not comprehensive as did not include all restrictions in use.

Behaviour support plans had been prepared for both residents, however one plan was over due a review and the other plan was not fully in line with the provider's policy. There was also a lack of clarity regarding the requirement for staff to complete positive behaviour support training to respond to and support residents with their behaviours.

The provider had not ensured that residents were adequately supported to participate and consent to decisions about their life as their communication needs had not been adequately assessed or promoted. Furthermore, residents were subject to practices that did not promote their privacy, such as night-checks and windows in their bedroom doors.

Regulation 17: Premises

The provider had not ensured that the centre were designed or laid out to meet the needs of the residents or kept in a good state of repair. The provider's previous plans to reconfigure and upgrade the premises to an appropriate layout and design had not materialised, and while they aware of the deficits in the environment and premises, they did not provide assurances to inspectors that alternative plans had been established. They also told inspectors that some works, such as the replacement of flooring, had been delayed until it was agreed what model of service was to be delivered in the centre and how the centre could be best designed to meet the needs of the two residents if they were to remain living there.

Inspectors observed the following in the apartment:

- The oven and a locked kitchen press required cleaning.
- The shelves in a unit in the sitting room had been removed and not replaced.

- There were discarded cigarette butts at the side of the apartment.

Inspectors observed the following in the main building:

- The resident's bedroom en-suite was not accessible to them, and instead used for storage.
- There was a large puddle of water in the boiler room from a leak.
- An unused bath, out of use for approximately three months, required replacement.
- In one of the bathrooms, the flooring and tiles were damaged, and the paint on a radiator was chipped.
- An insect control device in the kitchen was not being used and required removal.
- Sound proofing in the centre was poor which was impacting on both residents.

Overall, the centre presented an institutional aesthetic, for example, the large space and unused rooms were not homely, there was a high number of restrictive practices, and strong odors of cigarette smoke and cleaning chemicals were unpleasant.

Judgment: Not compliant

Regulation 26: Risk management procedures

The systems for the assessment, management and ongoing review of risk, including the system for responding to emergencies required improvement.

Inspectors reviewed the risk register for the centre, and found that several risk assessments required review and updating as some of the control measures were not in place, for example, use of 'child locks' in one of the vehicles, and two-to-one staff for one resident at night.

On the first night of the inspection, the deputy manager rang the on-call service (managed by the provider's senior service managers) at 8.15pm and again at 8.45pm to inform the provider of the unannounced inspection and of the inspector's presence. There was no answer at either time.

The deputy manager subsequently rang another three senior senior managers at approximately 9.10pm and received a call back from one of them at 9.14pm. They told the deputy manager and inspector that they were covering the on-call in the absence of the senior service manager with responsibility for the centre. The deputy manager was unaware of this arrangement, which showed deficits in the effectiveness of the on-call service which was also used to report emergencies.

Judgment: Not compliant

Regulation 27: Protection against infection

The registered provider had not implemented effective infection prevention and control (IPC) measures or arrangements following the previous inspection's poor findings in order to meet compliance with the associated standards.

The provider had prepared plans for the management of COVID-19 and other healthcare infections in the centre. However, the arrangements for the redeployment of staff to the centre required further review to ensure they would be effective.

Inspectors observed poor practices and management of known infection hazards and risks which posed a risk to the effective implementation of IPC measures to protect residents against infection:

- Hand-washing facilities were inadequate, as hand sanitiser was not readily available throughout the centre, and some hand-washing sinks did not have soap, paper towels or waste bins.
- Mop heads were observed drying on a bathroom radiator posing a risk of infection cross contamination.
- Soluble bags were not always stored in the appropriate location to minimise the risk of the spread of infection throughout the centre. For example, staff were required to travel through the centre from residents' bedrooms to the utility or bathroom to acquire alginate bags if there was soiled linen.
- In a bathroom, used by staff, cloth towels were used for drying hands, however there was no procedure or schedule for changing and washing the towels to reduce the risk of infection cross contamination.
- There was no local operating procedure to guide staff in the management of known soiled linen and laundry risks. Local managers created guidance during the inspection, however it required further review to ensure it best minimised the risk of transmission of infection.
- Inspectors saw that residents' laundry was not always separated from household laundry in line with best practice. For example, inspectors saw a dirty tea towel mixed with residents' clothes in a laundry bag.
- The cleaning chemicals for bodily fluid spills were not available in the apartment which posed a risk to the effectiveness and promptness of said cleaning. Inspectors also found from speaking to staff that they required more guidance in this area.
- While the centre was generally clean, some areas required attention. Inspectors saw that in the apartment, the door frame above the bedroom door and the wooden radiator cover were stained and required cleaning.
- Premises hazards posing infection risks required mitigation, such as damaged flooring, exposed screws in a bathroom wall, and a damaged arm rest of a shower chair repaired with duct tape which did not allow for thorough

cleaning of the shower chair.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not ensured that effective fire safety systems were implemented in the centre which posed a risk to residents' safety.

On the first night of the inspection, the inspector observed a fire evacuation plan, dated March 2021, displayed in the entrance hall of the main building. The plan required updating to ensure it was current. The plan was updated before the inspection concluded however, inspectors noted that further revisions were required.

For example, the evacuation plan referred to 'respite clients', at the time of inspection, the centre had been closed to respite service users and resident in the centre were living there on a full-time basis. While both residents that lived in the centre had individual fire evacuation plans outlining the supports they required, one of the plans required more clarification regarding equipment used by a resident.

The effectiveness of the fire containment arrangements was comprised. The inspectors observed the hinges of one fire door closure to be damaged. The fire proof glass above the office door in the apartment had been broken for approximately three weeks which impinged on its effectiveness, however it was fixed during the inspection. Inspectors released several of the fire doors, and found that two did not close fully.

The resident's bedroom in the apartment had a thumb lock mechanism on the inside of the room and required a key to open it from the outside if it had been locked. The deputy manager could not locate the key during the walk around of the centre which posed a risk of staff being unable to gain entry to the room during a fire if the door was locked from the inside. The deputy manager told inspectors that the resident would not be able to lock the door however, no risk assessment had been carried out in relation to this.

Inspectors were told that there was a designated smoking area behind the main house, however some staff smoked outside the apartment. There was an absence of documented guidance for staff in this matter, however a local operating procedure was implemented on the day of inspection.

Regular fire drills took place to test the fire evacuation plans, however there was a need for clear guidance from the provider on the number, frequency and location of fire drills to be completed. For example, inspectors saw that monthly fire drills were held with one resident, however the majority of these involved role playing a planned evacuation from the resident's car due to a hypothetical mechanical fault.

Day time drills had not taken place since January of this year with the other

resident. Inspectors were informed that the local managers had been verbally told not to carry out drills with this resident as it may cause them distress. There was no written guidance on this matter to support this verbal instruction.

Inspectors saw that a night time drill had been completed with both residents in the past seven months and that both residents evacuated the centre in a timely manner.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Overall, inspectors found that registered provider had not ensured that residents' needs were adequately assessed or that the arrangements in place to meet their needs were sufficient.

Recent multidisciplinary meeting minutes from May 2023 noted that the provider was exploring alternative accommodation and services to best suit some residents' needs. Recent multidisciplinary team assessments also noted that one resident "is isolated" and may be "lonely", and would benefit from "modification to the garden". Occupational therapy services had also made recommendations including two staff working at night in the apartment, and specific environment modifications. The provider was aware that the centre was not meeting all residents' needs, however, they had not determined a time bound plan to ensure that both residents' needs were being met.

Inspectors reviewed both residents' assessments of needs which were used to inform associated care and support plans. Inspectors found that the first resident's assessments were insufficiently detailed and that there was a failure to implement a personal plan that comprehensively reflected the resident's needs and outlined the supports they required to maximise their development in accordance with their wishes. For example, it was identified that a resident had a medium support need in the area of communication however this resident had not been referred to speech and language therapy for a communication assessment. While there was a communication passport on file, completed by staff members, there was no communication support plan that was informed by the relevant multidisciplinary professionals to document how staff could best support the resident to communicate their wishes and preferences.

Aspects of the assessment of need were found to be inaccurate. For example, it was detailed that there was a need in suctioning and oxygen therapy, however there were no care plans in place for these. On review with local managers, it was established that this resident did not require suctioning and that there was no suctioning equipment in the centre.

Inspectors were also informed that alternative accommodation had been considered for this resident, however this was deemed to be unsuitable. However, inspectors found that an appropriate assessment of the resident's ideal living arrangement had

not been carried out to determine what it would look like, for example, living with others or alone, and preferred geographical region.

Inspectors were informed that the provider was in the process of sourcing a specialised assessment to determine the particular support needs of some residents.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The registered provider had not ensured that restrictive procedures were been implemented in accordance with national policy and evidence based practice.

The restrictive procedures implemented in the centre included environmental and physical interventions, and rights restrictions, including locked presses, sensor alarms, and psychotropic medication. Inspectors also noted other restrictive practices that not been identified by the provider, such as a lap tray and belt, sensor mat, and night time checks on one resident while they were sleeping.

The inspectors were not assured that the provider had adequate oversight of restrictive practices in the centre and that these practices were in place for the shortest duration possible. Some restrictions had not been risk assessed, consented to, or approved by the provider's oversight group, for example, the nightly hourly checks and a sensor alarm.

Inspectors were informed that hourly night checks had been in place for one resident subsequent to a suspected fall from bed in the last number of years. Inspectors were told that, since the hourly checks had been introduced, there had been no documented falls from bed and no injury similar to the one that prompted the introduction of the checks. Inspectors were therefore not assured that this restrictive practice had been adequately reviewed and that attempts had been made to reduce or eliminate it. There was also no clear guidance for staff to follow on implementing the checks.

The practices for implementing restrictions was poor, for example, four presses were locked in the kitchen apartment, and the deputy manager could only locate the key to open two. One contained food and the rationale for locking it was unknown. The other locked press contained cleaning solutions, however the inspector observed similar cleaning solutions on open presses which conflicted with the rationale for locking away these cleaning solutions. It was unknown what was in the other two locked presses as they could not be opened.

Inspectors were informed by the local management team that behaviours of concerns had begun to reduce since the previous inspection and the addition of the behaviour support practitioner to the team was providing guidance to staff on the implementation of behaviour support plans. The first plan viewed by inspectors was not fully in line with the provider's restrictive policy, as it did not include all of the

restrictive practices in place, and it also did not include all behaviours of concern. The second plan was over due a review in October 2022. The person in charge had referred it for review in March 2023 and was awaiting same. Neither plan was signed by all staff to indicate that they read the plans.

There was a lack of clarity regarding the training requirements for staff in positive behaviour support. The statement of purpose referred to such training, however inspectors were informed that while staff receive guidance from the behaviour support team, there was no training provided.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had not ensured that the centre was operated in a manner that ensured residents had freedom to exercise choice and control in their daily lives, participated and consented to decisions about their care and support, or that upheld residents' rights to privacy and dignity in their home.

One of the resident's assessment of need identified that they required support with communication. However, there was no communication support plan on file which detailed how this resident should be best supported to make decisions about their care and support and to participate in the running of the designated centre.

There were inadequate measures in place to consult with the resident regarding the running of the centre. A weekly schedule was completed in a written format which inspectors were told was not accessible to the resident as they did not have the required literacy skills to understand the schedule. Inspectors were also told that the resident understood picture formats, but the schedule did not include any pictures that would have aided their understanding and participating in planning their activities.

The provider had set out in their previous compliance plan that the resident had been consulted with regarding the location of their bedroom in the house. The person in charge could not provide assurances that the consultation took place in a manner that best supported the residents' comprehension and in a format that facilitated them to make an informed decision regarding their living arrangements. It had also not been identified if and how residents were to be consulted with in order to ascertain their views and preferences on the plans being proposed for their living arrangements.

Both residents were seen to have windows in their bedroom doors which did not afford them adequate privacy in respect to their personal living space. Furthermore, hourly checks were completed on one resident during the night which further impacted on their right to privacy. These arrangements were managed by the provider to demonstrate that their privacy and dignity was respected.

Additionally, inspectors were informed that noise between the main building and apartment could adversely impact on both residents. For example, the resident in the apartment could become upset if they heard noise in the evening and night which could lead to them displaying behaviours of concern. Inspectors were informed that earlier in the year, the noise made by the resident in the apartment kept the resident in the main building awake during the night. The provider had not made adequate arrangements to ensure that this matter was addressed.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Hall Lodge OSV-0001709

Inspection ID: MON-0039699

Date of inspection: 17/07/2023 and 18/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC and PPIM has carried out a risk assessment for night-time staffing arrangements in conjunction with the providers Health and safety team. There is a support plan in place to provide guidance on what actions are required to support clients in each building communicated by email on the 15.08.2023. The provider is satisfied safe staffing levels are in place at night-time.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff that require refresher courses have been scheduled to attend refresher training by the 31st October 2023.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider continues to meet with funders on a regular basis, there has been some	

agreement reached. A timeline will be devised and confirmed with HIQA once this is determined.
Six monthly provider audit has been brought forward to 1st September with additional follow up Audit in December 2023.
The PIC and PPIM has carried out a risk assessment for night-time staffing arrangements in conjunction with the providers Health and safety team, there is a support plan in place to guidance on what actions are required to support clients in each building. The provider is satisfied safe staffing levels are in place at night-time.

The PIC has put in place additional hand sanitizers.
All bathrooms have paper towel dispensers installed.
Spill kits and instructions where to find these have been re issued to staff team.

Alginate bags have been relocated to client areas such as bedrooms and bathrooms so they are easily accessible.

The provider has since clarified the insurance of the client's vehicle via email on the 11th August 2023. The vehicle is insured, and staff are insured to drive it.

The PIC and Deputy manager are now aware of the schedule of fire evacuations to take place, these have been scheduled in for the coming year. The schedule of fire evacuation is set out in the location safety statement.

The policy has been reviewed by PIC and Deputy Manager. Fire evacuations have been scheduled in line with policy and discussed at team meeting on the 27.07.2023. The impact and effectiveness of evacuations will be monitored by management.
There is a night-time noise trial is in place which will be implemented on a phased bases with consultation and guidance from Behavior support Specialists. Positive behavior support plan highlights the benefits of introducing some predicable sounds such as cleaning, kitchen duties, tv etc. This was discussed at staff meeting 25.08.2023.

The centre has a clearly defined management structure which is outlined in the SOP. The centre is managed frontline by a full time PIC and .6 WTE Deputy Manager , the Centre and PIC is supported by PPIM, the PPIM reports to CEO , the CEO reports to the Borad of Directors. There are other support Departments such as MDT, Accounts lead by the financial controller , HR, Facilities, the centre has a designated HR Business Partner.
The PPIM has conducted probation reviews with PIC, the PPIM carries out on site visits and two governance checks per annum , the provider has an annual audit, two six month audit, medication audits and annual health and safety audit. The Facilities department conducts monthly audits in the centre. The PPIM meets the CEO monthly for 1:1 . The PPIM along with CEO and Senior Management team review the corporate risk register monthly , all risks over 15 in the PPIM'S area are added to the risk register. The Corporate risk register is shared with the Risk Management Committee , which includes Members from the Board of Directors, the Risk Management committee via the chair of the committee communicates to the Board of Directors. The PPIM provides a quarter report to the Senior Management team on their areas and highlights issues positive and negative . All Senior Managers engage with the CEO in an appraisal framework twice per year. All staff in the centre engage in an appraisal framework with the PIC and the PPIM conducts an appraisal with the PIC. The HR Business partner tracks the completion of the

appraisals based on their completion date in line with policy.
There are local cleaning checklists in place which are being reviewed daily by the PIC or Deputy Manager. The centres has an Health and safety rep would carries out safety checks . Keyworkers are requested to carry out a documentation Audit on the residents folder each ¼, this is then checked by the PIC or deputy Manager. There are monthly staff meetings held in the centre where information is shared and minutes.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
One resident contract of care has been updated and signed by all relevant parties on the 31.08.2023.

One resident's contract of care is currently being updated. SHS have been in consultation with external bodies regarding details contained in the contract of care. Upon receipt of clarification from external bodies, the family/advocates will be invited to review and sign the agreement. This will include a MOU in relation to the vehicle and any charges which the resident is responsible for. Expected date for completion 30.11.2023.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Flooring was repaired however due to the high level of usage further repair work is required. Floor will be part of the larger building works required with a target of quarter 3, 2024.

Exposed screws in a bathroom wall allocated to maintenance urgent works will be completed by 08.09.2023.

Damaged arm rest of a shower chair sent to supplier for review to assess if it can be repaired or will need to be replaced. To facilitate lead time for repair / delivery providing October 31st for completion date.

The shelving in the apartment will be repaired and placed on the 22.09.2023.

Buz zapper will be removed on the 22.09.2023.

The unused bath was removed from centre on the 28.08.2023.

There is a cleaning checklist in place , this will be monitored daily by PIC or deputy manager.

The Leak in the boiler room was repaired on the 20th of July the pump which had a small crack in the body causing a small leak was replaced.

A large padded headboard has been ordered with a supplier, this will be placed on the adjoining wall between both residents bedrooms and will provide a barrier to sound, the supplier has delays on the delivery and installation of the headboard , however the provider has contacted the supplier and had requested the delivery of the headboard and they will arrange the installation to avoid further delays, should there be further delays with the delivery the provider will make arrangements to collect the headboard.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A full review of risk has been completed with control measures updated to reflect the presenting needs of the residents. This was shared with staff 31.08.2023.

The provider has an emergency on call procedure in place, this has been clarified to the staff team. A hard copy of this is available in the staff office.

The PIC has drafted a detailed step by step procedure displayed on the staff office wall which was first trialled in April and resent via email to all staff on the 06.09.2023. This includes the point that on-call should be contacted.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Arrangement for redeployment to the center are being reviewed and documented. This

will be completed by the 15.09.2023.
The PIC has provided more hand sanitizers throughout the designated center. All sinks have soap and paper towels and waste bins. Radiator will be sanded and painted with rust protection paint by 31.09.2023
Mop heads now have a designated area to be dried in the outside cabin.
Alginate bags have been relocated to client areas such as bedrooms and bathrooms, so they are easily accessible. Towels have been removed and replaced with paper towels.
A procedure has been developed and shared with the staff team via email on the 31.08.2023 in relation to laundry and storage of soiled items. There is now guidance in place for staff around the storage of laundry communicated with the staff team via email on the 31.08.2023.
Spills kits have been replaced and there is a guidance document for staff on where further spills kits are stored if needed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The fire evacuation plan has been updated and the reference to respite clients has been removed. This discussed at staff meeting on the 23.07.2023 .

Residents PEEPS have been updated detailing the relevant supports and resources required.

Fire door was repaired on the 25.07.2023.
The fire proof glass was replaced on the day of inspection.
Locksmith has been booked with work due to be completed on the 08.09.2023
A designated smoking area has been identified for staff working in the apartment. Staff were informed of this on the 31.08.2023.
The PIC and Deputy manager are now aware of the schedule of fire evacuations to take place , these have been scheduled in for the coming year. The scheduled of fire evacuation is set out in the location safety statement.

The policy has been reviewed by PIC and Deputy Manager. Fire evacuations have been scheduled in line with policy and discussed at team meeting on the 27.07.2023. The impact and effectiveness of evacuations will be monitored by management

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A referral has been submitted to SALT in relation to communication assessment for one client due to be completed in September 2023.
The PIC and Keyworkers completed a review of one residents needs assessment, this has been now updated.
An external party commissioned by the providers funders will complete an assessment of need for one resident.
The initial steps have commenced 31/10/2023
On completion of the assessments the needs and appropriate supports required for the resident will be identified the Provider has notified verbally to the inspector further details around this.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Rights restrictions have been reviewed and sent to the human rights committee to ensure due process has been followed. Residents advocates have been informed of the rights restrictions and will be sent a copy for their review by 30th September 2023.
For each restrictive practice there is now a risk assessment in place. All restrictive practices will be notified going forward to the regulator.
Hourly checks have ceased this has been communicated to staff in team meeting on the email sent to staff team on the 30.08.2023.
Cleaning products are no longer stored in one residents presses as all presses will remain unlocked. as the resident can not safely use the cleaning products nor is aware of the dangers of these , these are now stored elsewhere.
Locksmith has been booked with work due to be completed on the 08.09.2023
Regular training is provided onsite to staff by behavior support practitioner which is tailored to be specific to the needs of the resident and the training focuses on the correct response to the behaviors that challenge. Additional support is provided monthly at team meetings by the behavior support practitioner.
Restrive practices are currently being reviewed by Behavior support to be included in the behavior support plan and due to be completed 30.09.2023.

The Behavior specialist has been contacted and will review one residents positive behavior plan 30/11/2023.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A picture board has been displayed in the main living area that is accessible to the client in deciding what activities they would like to participate in during the day.

Restrictive practices have been reviewed and updated and sent to HRC. These will be shared with residents family. A contractor has been sourced to apply a cover fling over the glass areas in the bedroom doors to ensure residents privacy to be completed 30/09/2023.

A large wall mounted padding has been ordered to reduce noise travelling between the apartment and the main building Due to be installed 31.09.2023.

Both residents are supported by their family members with decisions relating to service delivery. One residents family attends case review meetings , they have also been visited and consulted with by the providers social worker on matters relating to service delivery. One residents family are also in regular contact with the service and have expressed their views based on their knowledge and understanding of the resident and their preferences and goals. One resident is currently a ward of court and their family are part of their support committee.

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	15/08/2023
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	13/10/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/12/2024

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/12/2024
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/12/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2024
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	31/03/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Not Compliant	Orange	31/03/2023

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	30/11/2023
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	30/11/2023
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Substantially Compliant	Yellow	31/10/2023
Regulation 26(1)(a)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/09/2023

	risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	30/09/2023
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	30/09/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in	Not Compliant	Orange	30/09/2023

	place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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.	Not Compliant	Orange	30/09/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	08/09/2023
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	08/09/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and	Not Compliant	Orange	08/09/2023

	extinguishing fires.			
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	08/09/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	27/07/2023
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	23/07/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in	Substantially Compliant	Yellow	30/09/2023

	need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/10/2023
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/10/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/10/2023
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal	Substantially Compliant	Yellow	31/10/2023

	plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/09/2023
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.	Not Compliant	Orange	30/09/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with	Not Compliant	Orange	30/09/2023

	national policy and evidence based practice.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	30/09/2023
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/09/2023
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/09/2023
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with	Substantially Compliant	Yellow	30/09/2023

	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.			
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	30/09/2023
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	30/09/2023