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:	Pine Grove Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Short Notice Announced
Date of inspection:	06 July 2022
Centre ID:	OSV-0001782
Fieldwork ID:	MON-0037381

About the designated centre

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

Pine Grove Residential Service is a service run by Western Care Association. The centre is located near a town in Co. Mayo and provides residential care for up to five male and female residents who are over the age of 18 years and have an intellectual disability. The centre comprises of one premises, which provides residents with their own bedroom, shared communal areas and garden space. Transport arrangements are in place to ensure residents have regular opportunities to access the community and local amenities. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

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
Wednesday 6 July 2022	09:00hrs to 16:30hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

The inspection was a short notice announced inspection to monitor and inspect the arrangements the provider had put in place in relation to infection prevention and control. The inspection was converted to a risk inspection after two hours due to areas of concern identified and it was completed over one day. The inspector met with three members of staff including members of the management team, such as the person in charge, the person participating in management and one residential staff. The inspector met one resident briefly at the start of the inspection but was unable to meet the rest of the residents due to their assessed needs. The governance and management arrangements in place were not effective in ensuring this service was appropriate in meeting the assessed needs of the residents. In addition, on the day of this inspection, the inspector found that the service was not adequately resourced and issues were identified with the management of residents individual assessed needs, staffing levels, rights in regard to choice and access to activities and the management of maintenance in the centre. The inspector was assured that the management team had a meeting that morning to discuss areas that required improvement in this centre and completed a comprehensive review of the service,which included staffing and maintenance of this centre. At the time of the inspection, there was no clear time-bound plan was in place. The impact of these deficits included when three residents who were compatible went on a social activity with two staff; this meant that two residents were left with one staff. In addition, the staffing team ensured that all residents received a social outing or activity with two staff most evening but again this resulted in one staff remaining with four residents who all required varying levels of supervision as per their assessed needs. This did not allow residents adequate opportunities or choice in their daily lives.

The centre was large and spacious home for five residents, each of whom had their own bedroom. The house was nicely furnished and equipped, and had a large outside garden area to the front and rear of the centre, including a patio area and spacious lawns. Due to the number and nature of the residents assessed needs and compatibility issues there were difficulties in ensuring that residents were supported to engage in activities according to their preferences and choice. While the provider had ensured that the staffing level in place at the time of the inspection was in line with the statement of purpose, the inspector found that the current staffing level was not sufficient at all times due to the residents assessed needs and this resulted in limited opportunities for all residents.

While the centre required significant maintenance, the residents were receiving a good service within the current systems in place. The centre was homely and suitably decorated throughout and personalised to residents individual choice and preferences. The residents were supported by a caring and skilled group of staff however, staff spoken with acknowledged the issues of staffing levels and compatibility of all residents in the centre. Overall, the centre was clean, warm, free from debris and met the requirements of residents who lived there but improvement

was required to review the numbers and compatibility of residents in this service.

All of the residents' bedrooms were personal to them, and contained their personal items, including photographs and items relating to their hobbies and interests. It was clear that residents kept their rooms as they chose, with as many or as few items as they chose. While their rights were respected in the communal areas of the house, there was room for improvement in all residents' rights due to the limited choice and restrictions with social activities.

The next two sections of the report outline 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 delivered to residents living in this service.

Capacity and capability

Overall, while there was a robust management structure in place in the centre, the inspector found that while the provider had recognised the deficits in the centre, there was no quality improvement plan in place; which was time-bound, or showed the persons responsible for completing the actions. The governance and management failed to show compliance with the regulations as they failed to ensure that actions from the previous inspection were completed within the time frames they had submitted as part of their compliance plan response in July 2021.

The centre was subject to ongoing monitoring and review, the provider had carried out an annual review of the service and unannounced audits on behalf of the provider twice each year, and these processes had assisted in ensuring the oversight of this service.However, significant improvements were required which will be outlined in the quality and safety section. This included additional management meetings in response to changes in residents needs.The reports were detailed and comprehensive and included the views of resident's and their family's.

Other audits were also being carried out by the person in charge and staff to review the quality and safety of the service. A monthly audit plan had been developed and specific audits were identified to be carried out each month. These included audits of fire safety, finances, health and safety, medication, infection control and COVID-19 compliance, and restrictive practices. The required audits had been completed to date.

There arrangements in place to manage the centre, required review. The person in charge knew the resident's and their support needs, The person in charge was based in the centre and was readily available to all residents and staff when required. In addition, the inspector noted that staff were familiar with the managers and spoke in a positive manner. Staff spoken with had the opportunity to raise

concerns and acknowledged that these were recorded. Management meetings were not being completed as scheduled since September 2021. The person in charge had been absent for a period of time but the systems were not adhered to as required. Poor attendance at staff meetings were noted and this did not promote best practice in line with the local policies. Opportunities to share and discuss relevant information was limited as a result.

There were insufficient staff on duty to support the resident's assessed needs in the centre. The staffing arrangements in place meant there was limited opportunity or choice for residents to engage in activities of their choice or preference. On review of training records, the inspector noted there were measures to ensure that staff were competent to carry out their roles. Staff had received training relevant to their work, such as training in medication management, manual handling, food safety, and mandatory training.

In response to the recent pandemic, staff had attended additional training in various aspects of infection control. A wide range of policies and standard operating procedures were also available to guide staff.

Overall, while the provider and person in charge had not ensured there were effective systems in place to provide a good quality and safe service to residents, significant improvements were required to further improve the service provided to residents in this centre, this will be outlined in the next section of the report.

Regulation 15: Staffing

The number, skill-mix and qualifications of staff was not appropriate to the number and assessed needs of residents. As a result residents received limited opportunities or choice due to the staffing provision in this centre. In addition, residents were not always supervised as required. For example, a resident who required constant supervision as per their epilepsy management plan was not always supervised as specified, for periods of time.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had not ensured that staff development was prioritised and that the staff team had access to regular support and supervision. Team meetings had not been completed with a full staffing compliment since October 2021. On review of staff training records, staff had completed all mandatory training as required and in-

line with the organisation policy.

Judgment: Compliant

Regulation 23: Governance and management

The provider had an appropriate management structure in place, however, improvement was required to ensure a comprehensive review of this service with time-bound actions to address all areas that required improvement. This included actions identified from the previous inspection which had not been completed within the agreed dates. Whilst the provider had recently identified the issues highlighted in this report, there was no time-bound quality improvement plan in place to correct all of the issues.

Judgment: Not compliant

Quality and safety

The inspector found that residents were not receiving appropriate care and support throughout the centre which was person centred and focused on their needs. The inspector found that there was limited opportunity for all residents to access social activities of their choices and preferences due to the current operational systems of the residential service.

The centre was not being operated in a manner that promoted and respected the rights of residents. As noted earlier, residents were being supported to engage in limited activities due to staffing levels and compatibility issues, but residents were supported to maintain contact with family members and representatives regularly.

The provider had ensured that comprehensive assessments of residents' health and social care needs had been completed. A number of residents presented with complex needs, and their support plans were detailed and under review by the centre's management team and the provider's multidisciplinary team. There was evidence that these plans were treated as live documents and tracked the changing needs and supports required for residents. However, due to the residents' assessed needs, the inspector found that only three residents could travel for an outing together. This resulted that two residents who were deemed incompatible were brought on separate outings where possible. The last person admitted was noted as incompatible due to age and preferences. The provider had ensured that this resident received an individualised day service programme, but when this finished they were supported by the residential staffing who were managing five residents with varying supervision and supports required. A recent unannounced audit of the

centre showed that the provider and management team had recognised the gaps evident and were commencing a comprehensive review of the service. At the time of the inspection, no clear time-bound plan was in place to address these deficits.

There were appropriate systems in place to manage and mitigate risks and keep residents and staff members safe. The provider had arrangements in place to identify record, investigate, and learn from adverse incidents. There was an active risk register in place that captured the environmental and social care risks present in the centre. Residents' risk assessments were detailed and were linked to their support plans. These assessments were being reviewed, however improvement was required as the risk rating did not reflect changes in the centre such as equipment not working, and appropriate controls to address the issue.

Effective fire safety precautions were in place, including the fire detection, fire safety checks, emergency lighting arrangements and multiple exits were also available throughout the centre. Fire drills were occurring on a regular basis and records demonstrated that staff could effectively support residents to safely evacuate the centre. A personal emergency evacuation plan (peep) was in place for each resident which ensured that staff had guidance on how to support each resident required to evacuate. Improvement was required as an action form the previous inspection in July 2020 was not completed. This involved the lack of egress due to the poorly maintained pathways, and residents having to access the uneven lawn to exit safely from the centre to the nearest evacuation point, therefore, fire drills continued to use one exit point at all times. . In addition, the gates had not been maintained effectively and the inspector saw that the keys to access the gate were not easily accessible on the day of the inspection.

There were appropriate systems in place to manage and mitigate risks and keep residents and staff members safe. The provider had arrangements in place to identify, record, investigate, and learn from adverse incidents. There was an active risk register in place that captured the environmental and social care risks present in the centre. Residents' risk assessments were detailed and were linked to their support plans. These assessments were being reviewed and updated if required regularly. The inspector noted that a residents risk assessment did not reflect the current status of the monitoring equipment.

The inspector observed that residents had access to appropriate healthcare professionals. There were health plans, and risk assessments focused on promoting the health of residents, and these were under regular review. However, improvement was required as a resident who required constant supervision due to their epilepsy status could not receive this due to the current staffing arrangements. In addition, the inspector noted that a epilepsy monitor was broken at the time of inspection. The person in charge a temporary replacement monitor during the inspection, whilst they awaited a suitable replacement monitor.

Overall, the inspector found that the care within the service was not delivered in a person centred manner and the quality of the residents' lives required review and improvement

Regulation 17: Premises

Overall the centre was designed and laid out to meet the needs of residents, however, improvement was required in areas of the centre, this included;

- painting- walls, skirting, radiators and dado rail

-water damage on kitchen kick-board,

-review of all kitchen units internally and externally due to water damage and discolouration, evidence of debris on cupboard door frames

- repair works internally and externally for example, garden gates, perspex screen cover where mops were stored and replacement of mop head hanging units,

- review of bathroom storage as no doors in place

- no handles on storage units in dining area

- two replacement leather armchairs with worn leather which did not promote effective cleaning

- Dust and debris were noted in areas throughout the centre in particular behind open doors and corner units/areas, in all residents bedrooms

- all window sills require cleaning

- crack in flooring between lounge and kitchen

- toilet seat marked and discoloured

- appropriate seals required on bathroom fittings- gap in door jam

- A back door had mould evident on frame and another patio door did not open or close correctly.

- items stored in sensory room such as wheelchairs, and other miscellaneous items.

- in bathroom areas piping exposed and not covered leading to dust and debris.

Judgment: Not compliant

Regulation 26: Risk management procedures

The actions from the last inspection had been completed, but the inspector noted that the individual and centre risk assessments were not updated to show controls that were required at the time of the inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had not addressed actions from the previous report in July 2021 and continued to have a limited access and eggress facility for all residents, as a result; while fire drills were completed, they continued to use the main access and exit point of the centre which did not promote good practice or the opportunity for learning.

Judgment: Substantially compliant

Regulation 6: Health care

The provider had ensured that residents were offered and receiving appropriate healthcare when required. On the day of the inspection, the inspector found that a epilepsy monitor required repair and had not been in use for a period of time, therefore the resident was not monitored as required at all times in the centre. On the day of the inspection, the person in charge obtained a temporary replacement epilepsy monitor, whilst awaiting an appropriate replacement monitor suitable to meet the residents' assessed needs.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had ensured that there were appropriate systems in place to respond to residents behaviour support needs, and that they had access to appropriate support from allied health professionals as required.

Judgment: Compliant

Regulation 8: Protection

The provider had ensured that there were appropriate systems in place to respond to safeguarding concerns.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider did not provide each resident with appropriate care and support in accordance with best practice, taking into regard each resident's disability, assessed needs and their wishes. In addition, there was limited opportunities to participate in activities in accordance with their interests, capacities and development needs.

Judgment: Substantially 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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 13: General welfare and development	Substantially compliant

Compliance Plan for Pine Grove Residential Service OSV-0001782

Inspection ID: MON-0037381

Date of inspection: 06/07/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Training All staff will have been nominated and will have completed Epipen, Epilepsy Management and FEDs training by November 30th 2022. Additional Staffing Resources Additional staffing resources for evenings and weekends have been agreed to create further opportunities for service users to participate in activities of their choosing and to ensure appropriate adherence to epilepsy management guidance for one service user. This will be fully in place by 15th September 2022. Service Review: A full service review is currently underway to examine and assess best use of resources and compatibility within the service. This will be completed by 15th September 2022	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Governance and Management: A Service Governance Structure will be introduced whereby monthly governance team meetings are carried out and a monthly report developed outlining adherence to key performance indicators including, but not limited to adherence to previous actions from HIQA reports, as well as Internal Quality Audits and Inspections, Risk and Property maintenance. Any outstanding actions will be identified to Senior Management and will inform the Risk register. This will be in place by 15th September 2022.	

Additional Staffing Resources
Additional staffing resources for evenings and weekends have been agreed to create further opportunities for service users to participate in activities of their choosing and to ensure appropriate adherence to epilepsy management guidance for one service user. This will be fully in place by 15th September 2022.
Service Review:
A full service review is currently underway to examine and assess best use of resources and compatibility within the service. This will be completed by 15th September 2022
Compatibility: A plan to address compatibility issues including transition planning will be completed by 1/6/23. The provider will update HIQA at regular intervals with progress updates.
Risk Register: The risk register updated to reflect the equipment that was out of order, and amended when the equipment was fixed.
Fire: The pathway for fire exit purposes to the right hand side of the garden has been cleared fully and is fit for evacuation purposes. This will be used in fire drills. Extensive work on the garden, including leveling, reshaping, re-planting clearing of trees, as well as the development of a new gateway to the left of the garden for alternative evacuation purposes will be completed by December 31st 2022. Fire drills will incorporate all emergency exits throughout the year.

Epilepsy Monitor: Is currently working and an additional monitor was purchased as to have a backup available if required.
Additional staff resource has been agreed to ensure appropriate adherence to epilepsy management guidance for one service user.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Armchairs: ordered and will be delivered by September 20th 2022.

Maintenance and Property Issues Identified in the Report.
Facilities manager, Health & Safety Manager, Maintenance Manager, RSM and PIC met in August to devise a plan and schedule of works for the maintenance work to be completed – all work will be completed by December 31st 2022. Kitchen will be designed in consultation with staff to ensure minimal disruption to the service.
Cleaning
Daily cleaning checklist updated and a weekly external cleaner sourced – starting 15 September 2022.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A Service Governance Structure will be introduced whereby monthly governance team meetings are carried out and a monthly report developed outlining adherence to key performance indicators including, but not limited to adherence to previous actions from HIQA reports, as well as Internal Quality Audits and Inspections, Risk and Property maintenance. Any outstanding actions will be identified to Senior Management and will inform the Risk register. This will be in place by 15th September 2022.

Additional staffing resources for evenings and weekends have been agreed to create further opportunities for service users to participate in activities of their choosing and to ensure appropriate adherence to epilepsy management guidance for one service user. This will be fully in place by 15th September 2022.

The pathway for fire exit purposes to the right hand side of the garden has been cleared fully and is fit for evacuation purposes. Fire drills will incorporate all emergency exits throughout the year.

The epilepsy monitor Is currently working and an additional monitor was purchased as to have a backup available if required.

All staff will have been nominated and will have completed Epipen, Epilepsy Management and FEDs training by November 30th 2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The pathway for fire exit purposes to the right hand side of the garden has been cleared fully and is fit for evacuation purposes. This will be used in fire drills. Extensive work on the garden, including leveling, reshaping, re-planting clearing of trees, as well as the development of a new gateway to the left of the garden for alternative evacuation purposes will be completed by December 31st 2022. Fire drills will incorporate all emergency exits throughout the year.

The Fire Drill record has updated to identify what fire exit was utilized on each fire drill - Fire drills will incorporate all emergency exits on different occasions during the year.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: Epilepsy Monitor repaired and a back-up monitor purchased. Additional staff resource has been agreed to ensure appropriate adherence to epilepsy management guidance for one service user. This will be fully in place by September 15th 2022	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: Service Review: A full service review is currently underway to examine and assess best use of resources and compatibility within the service. This will be completed by 15th September 2022 Compatibility: A plan to address compatibility issues including transition planning will be completed by 1/6/23. The provider will update HIQA at regular intervals with progress updates. Additional Staffing Resources Additional staffing resources for evenings and weekends have been agreed to create further opportunities for service users to participate in activities of their choosing and to ensure appropriate adherence to epilepsy management guidance for one service user.	

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	15/09/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	15/09/2022
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	Not Compliant	Orange	30/11/2022

	purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	15/09/2022
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	31/12/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	15/09/2022
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any	Not Compliant	Orange	24/08/2022

	repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	31/12/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	15/09/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Not Compliant	Orange	15/09/2022

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	26/08/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	15/09/2022
Regulation 28(2)(c)	The registered provider shall provide adequate	Substantially Compliant	Yellow	24/08/2022

	means of escape, including emergency lighting.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	24/08/2022
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.	Substantially Compliant	Yellow	24/08/2022
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	15/09/2022