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:	Glenamoy
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	01 July 2022
Centre ID:	OSV-0002382
Fieldwork ID:	MON-0037212

About the designated centre

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

Glenamoy is a designated centre operated by Saint Michael's House located in a campus in North County Dublin. It provides a residential service to six adults with a disability. The designated centre is a bungalow which consisted of a living room, a kitchen, dining room, a conservatory, six individual bedrooms, a staff bedroom, an office and a shared bathroom. The centre is staffed by the person in charge, nursing staff, social care workers, health care assistants and domestic staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 1 July 2022	10:00hrs to 17:30hrs	Amy McGrath	Lead
Friday 1 July 2022	10:00hrs to 17:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This report outlines the findings of an unannounced inspection of Glenamoy. The inspectors ensured physical distancing measures were implemented as much as possible with residents and staff during the course of the inspection and also wore personal protective equipment (PPE).

The inspectors arrived to the centre and were greeted by a member of staff. The staff nurse in charge facilitated the early stages of the inspection and the person in charge attended in the afternoon. The inspectors met with all residents and observed them in their home during the course of the inspection. The inspectors used these observations, in addition to a review of documentation, and conversations with key staff to form judgments on the residents' quality of life.

The centre comprises of a six-bedroom bungalow located in a campus based setting in a North Dublin suburb. The premises was comprised of a large bright entry way, modest sized kitchen and separate dining room. There was also a large living area, a storage area and utility, a staff office, a conservatory, and two fully equipped accessible bathrooms.

Each resident had their own bedroom which was decorated in line with their personal preferences. Residents' bedrooms were well furnished and contained personal items and soft furnishings such as family photographs and albums. While residents enjoyed the use of their own personal space, inspectors found that some practices in place in the centre did not uphold residents individuality and were institutional in nature. For example, the utility room contained a large container of socks which were said to be used for all residents. Residents did not have their own socks in their bedroom and shared from a communal supply. Inspectors noted that a nail scissors and clippers in a shared bathroom were rusted, and were not designated as being for single person use, which presented an infection control risk.

One of the bathrooms was equipped with an accessible bath, which at the time of inspection was awaiting replacement. Parts of the bath were leaking, some fixtures were held on with tape and there was a build up of mould in some places.

Residents were supported by a team of staff nurses, social care workers and healthcare assistants. There was also a housekeeping staff employed on a part-time basis with responsibility for environmental hygiene. Staff interactions with residents were observed to be friendly and respectful. Staff were aware of residents' communication methods and responded to requests in a caring and prompt manner. For example, one resident caught the attention of a staff member through use of a non-verbal cue, who knew that they were seeking help to change the music they were playing in their bedroom.

Meals were prepared in the home by a chef who was employed on a part-time basis. At the time of inspection the chef was observed preparing lunch and an evening

meal for residents. It was noted that residents had opportunities to make decisions about what meals were served. Inspectors observed that an alternative evening meal was prepared for one resident as the chef was aware they did not like the meal prepared for all other residents. It was also observed that residents' specific dietary needs were well catered for. While the kitchen was well equipped, some of the cabinets were well worn and one was broken, with a piece of wood missing leaving the contents exposed.

The inspectors met with all residents throughout the course of the inspection. Three residents attended day services on a part-time basis during the week. One resident had a part-time personal assistant who supported them to engage in preferred activities. One resident was engaged in a swimming programme in a nearby leisure centre and planned to return to day services once the programme was complete. One resident had decided not to return to day service once it reopened, having been closed during the COVID-19 pandemic, as they preferred to engage in a more relaxed programme of activities in their home.

Throughout the inspection, inspectors observed residents watching television in the shared living room and enjoying meals and snacks together in the dining room. Residents appeared comfortable in each others company and there was a relaxed atmosphere in the home. Some residents went for a drive to the coast in the morning of the inspection, and another resident used the centre's transport to go on an activity in the afternoon. During the time the bus was occupied in the afternoon, one resident communicated that they wanted to go on the bus by using an object of reference. The resident became visibly agitated and attempted to communicate their request to multiple staff members, who explained that the bus was occupied.

At time of inspection, there were no restrictions in place with regard to visitors. Records indicated that residents received visitors to their home and also visited their family members' homes. Residents were also supported to receive and make phone calls to family members.

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

Capacity and capability

Overall, the provider had satisfactory governance and management systems in place within the designated centre to ensure that the service provided to residents was safe, appropriate to their needs, and consistently and effectively monitored. However, there were longstanding issues relating to the premises and in particular, regarding the upkeep and poor state of repair of the centre’s utility room, which impacted on the effectiveness of the infection prevention and control measures in place. While the person in charge had made the provider aware of the issues, it was found that the work was not completed in a timely manner. This is discussed further

under Regulation 27.

The centre was resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose. There was a clearly defined management structure that identified the lines of authority and accountability and staff had specific roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a service manager, who was knowledgeable about the support needs of the residents. Team meetings took place regularly which promoted shared learning and supported an environment where staff could raise concerns about the quality and safety of the care and support provided to residents.

There were effective management arrangements in place that ensured, for the most part, the safety and quality of the service was closely monitored. Improvement was required to ensure that the arrangements in place to monitor medicine stocks were adequate, this is discussed in further detail later in the report. The provider had carried out an annual review of the quality and safety of the centre, and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis. While there were some areas that required attention in order to fully comply with the relevant regulation, most of these had been identified by the provider through their own audit system, and action plans were being implemented to address them.

The registered provider ensured that the qualification and skill-mix of staff was appropriate to the assessed needs of the residents. Nursing care was available to residents as outlined in the statement of purpose. While there was a planned and actual roster available, the roster did not contain sufficient information to clearly identify staffing arrangements, and required improvement to accurately record and reflect the staff names, grades, and shifts worked in the centre.

The provider had ensured staff had access to training and development opportunities in order to carry out their roles effectively. Training was made available in areas specific to residents' assessed needs. There were established supervision arrangements in place for staff.

There was a complaints policy and associated procedures in place. The provider had made available a complaints procedure for residents that was in an accessible format and there were a number of systems in place whereby residents or families could raise an issue if they chose to. However, improvements were needed to ensure that a copy of the complaints procedures and protocols were displayed in a prominent position in the designated centre.

Regulation 15: Staffing

The staffing arrangements were found to provide continuity of care to residents. Staff had the necessary skills and experience to meet residents' assessed needs. While there was a planned and actual roster maintained, it was found not to

accurately or clearly record the staffing arrangements in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge monitored staff training and development needs and there were adequate arrangements in place to ensure that staff had the required training to carry out their roles. There was a programme of refresher training available. Staff received supervision in accordance with the provider's policy.

Judgment: Compliant

Regulation 23: Governance and management

Overall, there were satisfactory governance and management systems in place to ensure that the service provided to residents was safe and met their assessed needs. The provider had completed an annual report of the quality and safety of care and support in the designated centre in 2021 and there was evidence to demonstrate that the residents and their families were consulted about the review.

The provider commissioned an unannounced visit to occur in the centre every six months following which a written report on the safety and quality of care was produced. This report informed an action plan which endeavoured to address any concerns regarding the standard of care and support. On the day of the inspection, the person in charge had completed most of actions from the previous unannounced visit report.

A range of other audits occurred on a scheduled basis, such as a health and safety audit which had been carried out in April 2022. These audits informed a quality enhancement plan that was overseen by the person in charge and service manager, with a view to achieving compliance with the regulations and associated National Standards.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had developed a complaints procedure in an accessible format which was available to residents. Senior management advised the inspectors that a copy of the centre's complaints procedure was attached to the annual review of the quality

of care and support provided to residents, which was sent to families on an annual basis.

However, some improvements were needed to enhance the systems in place to ensure residents and families were aware of the complaints procedures. The inspectors found that a copy of the complaints procedure had not been displayed in a prominent position in the centre.

Families had submitted compliments regarding the service through feedback forms and greeting cards. On the day of the inspection there were no open complaints.

Judgment: Substantially compliant

Quality and safety

Overall, this inspection found that the provider and person in charge were operating the centre in a manner that ensured residents were in receipt of a service that was person-centred and offered a comfortable and pleasant place to live. There were some practices observed that were institutional in nature and needed to be addressed to fully facilitate a service that respected residents' individual needs and identities. Some areas of the premises needed to be repaired or replaced to ensure good infection control practices could be adhered to. It was found that residents' safety and good health was promoted, although improvement was required in the identification and recording of restrictive practices. Additionally, while medicines management was generally found to be effective, there were deficits in the auditing system and provision of PRN (medicines to be taken as the need arises) medication stocks.

Inspectors found that residents were receiving appropriate care and support in line with the nature and extent of their disability and assessed needs. Residents were provided with opportunities to participate in activities in their local community. Residents were also supported to develop and maintain personal relationships and link with the wider community in accordance with their wishes. However, the inspectors found that the documentation of residents' personal and social care needs and plans required review to ensure that they clearly recorded the actions taken to meet residents' individual needs.

The design and layout of the premises was suitable in meeting residents' needs. Each resident had their own bedroom, there was ample communal space and appropriate equipment to ensure the premises and facilities were accessible to all residents. There was a modest sized garden to the rear of the property, which had been paved and provided a wheelchair accessible route around the garden, however at the time of inspection some areas were overgrown and the pavement needed to be cleared of debris and weeded to ensure accessibility.

There was a designated utility room which was used for laundry management.

There was a hand-wash sink available, although the floor area was cluttered in places and restricted easy access to the sink. The cabinets in the utility room were found to be damaged by a heavy build up of mould, which was known to the provider. There was a plan in place to fully refit the utility room, which was discussed with inspectors by senior management. This issue required timely address to ensure that laundry facilities were clean and fit for purpose.

Staff had received training in infection prevention and control, and there was evidence that staff were familiar with standard and transmission based precautions. However, some practices in the centre did not align with good infection control practice and needed to be addressed, such as the use of shared equipment and storage of clinical waste containers.

The inspectors reviewed the arrangements in place to support residents to manage their behaviour. Overall, the provider and person in charge promoted a positive approach in responding to behaviours that may challenge residents or their peers. The inspector found that staff had been provided with specific training in positive behaviour support that enabled them to provide care that reflected evidence-based practice. Notwithstanding, the inspectors found that improvements were needed to ensure that where residents required therapeutic interventions, there was adequate guidance in place to ensure a consistent approach at all times.

There were a number of restrictive practices in place in the centre. For the most part, where applied, restrictive practices were clearly documented and were subject to review by the appropriate professionals. However, not all restrictions were applied in accordance with the resident's behaviour support plan, and as such, the provider could not be assured that the least restrictive procedure for the shortest duration necessary was in use.

The inspectors reviewed the safeguarding arrangements in place and found that residents were protected from the risk of abuse. The person in charge had ensured that all staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

The provider and person in charge had put in place safeguarding measures to ensure that staff providing personal intimate care to residents who required such assistance, did so in line with each resident's personal plan and in a manner that respected each resident's dignity and bodily integrity.

Residents received support to manage their medicines. Staff had received training in medicines management and administration of medicines. It was found that there were suitable storage arrangements in place for medicines. Deficits were found in the auditing arrangements for medicines, and stock control sheets were found to be completed to varying standards which did not always facilitate accurate record keeping. It was further found that some medicines which were prescribed to residents on a PRN (medicines taken as the need arises) basis were not available in the centre. This meant that the provider could not ensure that the medicine could be administered to the resident when required.

There were a range of fire safety systems in place. There was a detection and alarm

system in place that was serviced regularly. There were suitable emergency lighting and containment measures in place, and fire-fighting equipment was available and also serviced as required. One fire exit route was found to be obstructed by furniture stored in a patio area outside an exit located on a main corridor. This meant that if required, residents who use wheelchairs or other aids to evacuate, would not be able to reach the evacuation point. This was brought to the attention of a staff member by inspectors and was addressed on the day of inspection.

Regulation 13: General welfare and development

Residents enjoyed activities such as swimming, going for walks at a nearby harbour and local parks. Some residents attended local day services. Residents were also supported to develop and maintain personal relationships and friendships in accordance with their wishes.

Families played an important part in the residents' lives and staff acknowledged these relationships and where appropriate, actively supported and encouraged the residents to connect with their family on a regular basis. During the COVID-19 pandemic residents were supported to meet with their family in a way that ensured their safety.

The inspectors found that a review of the systems in place to record residents activities was required to ensure that residents' personal plans (including activity logs) clearly demonstrated that residents were engaging in activities that were meaningful to them and that were in accordance with their interests, capacities and developmental needs.

As some residents engaged in activities in their home, some improvements to the facilities, such as accessibility of the garden, was necessary to ensure the home provided sufficient resources for a varied and engaging activity programme. Additionally, while there was evidence that residents were receiving care and support that met their individual needs, some practices were found to be somewhat institutional in nature and required review.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While there were some good practices found in relation to infection prevention and control, there were a number of risks present in the centre that required timely action. The utility room was found to be in a state of disrepair with heavy mould build up in the bottom cabinets. Some of the doors had started to rot and their was mould on the base of a number of cabinets. The sink in the utility room was inaccessible due to items stored in the room and the sink itself was stained with

limescale. There was also mould present on the walls and ceiling of a bathroom.

Deficits were found in the arrangements for cleaning and decontaminating equipment. For example, some parts of the bath had mould present despite being cleaned. Some smaller equipment (nail scissors and clippers) were found to be rusted and were not designated for single person use.

Judgment: Compliant

Regulation 28: Fire precautions

While there were a range of effective fire safety precautions in place, action was required to ensure exit routes remained clear. It was observed that a secondary exit route was blocked by furniture stored on the outside patio area, this was despite daily fire checks noting that exits routes had been checked. Two break glass units were found to have glass missing which compromised the security of the emergency exit keys.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors reviewed the auditing systems in place and found that the arrangements in place for receiving, and recording the balance of medicines was not effective. A review of records found that a consistent approach had not been taken, and when checked by inspectors, some balances of medicines were considerably different than those on record.

The provider had not ensured that all medicines prescribed to residents were available in the centre, which meant that if required urgently, it could not be guaranteed that residents could receive medicines as prescribed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Where appropriate, there were positive behavioural support plans in place to guide staff in supporting residents in this area. On the day of the inspection, a number of plans had been recently reviewed and the person in charge had put arrangements in place for staff to familiarise themselves with the plans. The plans included a number of strategies and de-escalation techniques to guide staff on how to best support

residents during times when their behaviour could negatively impact themselves or others. However, where therapeutic interventions had been recommended, not all plans clearly demonstrated at what stage the intervention should be implemented. This meant that the information in the plan was insufficient to adequately guide and support staff to manage behaviours that was challenging in a consistent way.

On review of other documentation related to behaviour support, the inspectors found inconsistencies regarding when a recommended intervention had been implemented. For example, in some cases the documentation noted that redirection strategies had been implemented in advance of the therapeutic intervention however, this was not always the case. In addition, the use of the intervention had not been adequately risk assessed and guidance available to staff as to how to administer the intervention was not clear.

Consequently, while it was evident that where a resident had a range of supports in place that were guided by appropriate healthcare professionals, the provider had not been able to clearly determine if the intervention was restrictive in nature.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had ensured that there were systems in place to safeguard residents from all forms of potential abuse. Staff had received training in relation to safeguarding residents. There were clear lines of reporting and any potential safeguarding risk was escalated and investigated in accordance with the provider's safeguarding policy.

Where residents required assistance with their personal care, there were support plans in place that guided care that was dignified and upheld residents' preferences and wishes.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glenamoy OSV-0002382

Inspection ID: MON-0037212

Date of inspection: 01/07/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Under Regulation 15 (4): • The Person in Charge has implemented a roster system that demonstrates an actual roster, showing staff on duty during the day and night.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Under Regulation 34 (1) (b) • The Person In Charge has updated the centre with a visual complaints policy within all main areas of the centre • The Person in Charge and staff team have implemented an accessible complaints policy within all residents weekly meeting • The Person In charge has published the complaints policy within visiting area's of the Centre for family and visitors to avail of.	

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Under Regulation 13 (2) (b)

• The Person In Charge has devised and implemented a daily and monthly template to review all activities completed by residents within the Centre.

• An activity log and support review was implemented in order to review activities participated in were enjoyed by residents and developed further in their taste to ensure that activities did not become rigid and institutional

Under Regulation 13 (2) (a)

• Technical Services Department will complete essential maintenance work to the garden area in order to provide greater accessible access for residents to complete varied and engaging activities that are offered within the centre

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Under Regulation 28 (2) (b) (i):

• Glass had been replaced within 2 highlighted the break glass panels and same added to daily fire checklist

• Clutter and furniture had been removed from identified fire exit areas and same is placed within the daily fire check of the centre

• Fire door placement to pantry has been scheduled with TSD and Fire Officer

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Under Regulation 29 (4)(d)

• The Person in Charge has implemented a weekly checklist for ordering and maintaining PRN medication management within the Centre.

• The Person in Charge has devised a local policy for Medication Management in relation to ordering of PRN medication and out of hours Pharmacy practice.

• The Person In Charge has implemented a weekly checklist to ensure greater oversight, consistency and accountability for medication management and storage within the Centre

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Under Regulation 07(4):

• The Person In Charge and relevant Clinical support reviewed all elements of the positive behavior support plans, updating current procedures and guidance for staff to ensure that where physical, chemical or environmental restraints are used they are applied in accordance with national policy, organization policy and evidence based practice. Review schedule was updated in line with clinical guidance

Under Regulation 7 (5)(B):

• The person in charge and relevant clinics have reviewed each individuals PBS support plan to ensure that where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.
• The Person In Charge has completed a weekly template for monitoring the implementation of PBS plans and interventions implemented in order to ensure that all alternative measures are being considered and in order to identify key changes within the environment for residents

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	06/07/2022
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	04/07/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	04/07/2022
Regulation	The registered	Substantially	Yellow	02/07/2022

28(2)(b)(i)	provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Compliant		
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	15/07/2022
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	06/07/2022

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 national policy and evidence based practice.	Substantially Compliant	Yellow	06/07/2022
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	06/07/2022