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:	Mullingar 5
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	28 September 2021
Centre ID:	OSV-0002760
Fieldwork ID:	MON-0029015

About the designated centre

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

This designated centre offers a full time residential service to three residents over the age of 18 in a detached bungalow in close proximity to the nearest town. Each resident has their own bedroom which will be personalised in accordance with their preferences.
In addition to personal bedrooms, there are adequate communal areas, including a living room, kitchen and dining area. There is a large enclosed garden to the rear, and a lawned front garden.
The provider describes the support offered as being based on a social model of care for individuals with high support needs. Support is offered to people with an intellectual disability, autism, sensory needs and complex medical needs.
Staffing will be provided on a 24 hour basis, with waking night staff, and numbers and skill mix will be in accordance with the needs of residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 - 2015 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
Tuesday 28 September 2021	10:00hrs to 16:20hrs	Florence Farrelly	Lead
Tuesday 28 September 2021	10:00hrs to 16:20hrs	Karena Butler	Support

What residents told us and what inspectors observed

The inspection took place in a manner so as to comply with current public health guidelines and minimise potential risk to the residents and staff.

Inspectors met with all three of the residents on the day of inspection. While residents were not able to communicate verbally what it was like living in this centre, they appeared relaxed by their body language and were observed smiling at times. Residents were observed having tea, eating their lunch and relaxing in the dining area. Residents could freely access all areas of their home and at different times of the day some residents chose to spend time in their bedrooms.

Inspectors were informed by the person in charge that residents in this centre avail of an in-house day programme specific to their needs. Residents went for a drive with staff in the late afternoon on the day of inspection however, outside of this there was no evidence of activities being undertaken with residents during the remainder of the day. There was no evidence of in-house activities available for residents to use, such as sensory objects, jigsaws or DVDs. Residents spent the majority of the day sitting around the dining room with no activities. While residents' basic needs were being well catered for their opportunities for social inclusion and social stimulation were lacking. This will be discussed further in section two of the report.

Each resident had their own bedroom and each area of the house was easily accessible. All three residents were consulted with and agreed for inspectors to see their bedrooms and two residents chose to be present at the time to show off their rooms. The bedrooms were observed to be decorated to their personal tastes and contained personal items and pictures. There was adequate storage for their clothes and personal belongings. The centre had a spacious back garden with newly purchased garden furniture and a swing bench for residents to enjoy. The garden was easily accessible for residents with steps or separate ramps

During the inspection there were two care staff on duty in addition to the person in charge, all staff were very knowledgeable on the residents' preferences and supports required. Staff were observed to interact with them in a caring and respectful manner and residents appeared content in their company. Inspectors observed jovial interactions between staff and residents at different times throughout the day.

Residents were being included in the running of the centre where possible and this included regular residents meetings which were held in the centre with a number of areas being discussed. Areas included, health and wellbeing, maintenance and general upkeep, COVID-19, social and meal planning in the centre.

Residents' representatives had been offered the opportunity to give their views on the quality and safety of care their family members were receiving. Those spoken

with, expressed that they were extremely happy with the service being provided. They expressed that they felt comfortable that they could raise concerns if required.

Overall inspectors found that residents were being supported with their personal and healthcare needs in this centre. However, there were significant improvements required in residents general welfare and development. Some improvement was required in relation to the statement of purpose, staff training and development, healthcare, positive behavioural supports and premises.

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

Capacity and capability

Overall, inspectors found the centre was adequately resourced. There were management systems in place to ensure good quality care was being delivered to the residents however, improvements were required in relation to staff training and development, healthcare, positive behaviour support, general welfare and development, and premises will be discussed in section two of this report.

There was a statement of purpose available in the centre for review and it was found to be updated regularly. It contained most of the information required by Schedule 1 of the regulations. However, it did not contain details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision nor arrangements for residents to access religious services of their choice.

There was a defined management structure in place which included an experienced person in charge who worked on a full-time basis. The person in charge demonstrated to the inspectors that they were knowledgeable regarding the centre and knew the residents well.

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.

There were a range of local audits and reviews conducted in areas, such as incident management, medication management, and health and safety. From a sample of audits viewed, necessary corrective actions identified had been addressed by the provider.

From a review of the rosters inspectors saw that there was a planned and actual roster in place which was maintained by the person in charge. There was a consistent staff team employed in the centre and there were sufficient staff on duty

to meet the assessed needs of the residents.

Staff spoken with told inspectors that they felt supported in their role and were able to raise issues or concerns, where necessary, to the person in charge. Through staff supervision records it was evident that all staff had received formal supervision this year. Monthly staff meetings were occurring in the centre and from a sample viewed agenda items discussed included restrictive practice review, care plans, risk management, complaints, management of COVID-19/infection control and safeguarding.

The staff training records showed that staff were provided with a number of training opportunities to enable them to support the residents. Training included, safeguarding vulnerable adults, fire safety, the safe administration of medication, and manual handling. However, a sample of records viewed indicated that a number of staff were overdue refresher training with regard to basic first aid, management of actual or potential aggression and transport training that was deemed by the provider as training required to support the residents.

There was a residents' directory in place that was made available to inspectors. It contained all of the information required under Schedule 3 of the regulations.

Inspectors reviewed transition plans for all three residents who moved into the centre in 2020. Plans included protocols, visits, assessment of current needs, a contract of care and pictures of the new house. The plans were comprehensive and residents were introduced gradually to their new house. This was to ensure residents transitioned safely with as minimal disruption to their lives as possible. The contracts of care were all up to date, signed and included fees charged to the residents.

From a review of incidents that had occurred in the centre since the last inspection, the person in charge had notified the Chief Inspector of Social Services in line with the regulations when an adverse incident had occurred in the centre.

The provider had suitable arrangements in place for the management of complaints. There was complaints procedure and there was also an easy-to-read version displayed in the centre. A review of the complaints log showed all complaints received were recorded and followed up.

Regulation 14: Persons in charge

The person in charge was experienced and worked on a full-time basis. They were knowledgeable regarding the residents and the running of the centre.

Judgment: Compliant

Regulation 15: Staffing

There were adequate staffing in the centre to meet the needs of the residents. Staff were knowledgeable and were observed to interact in a gentle and kind manner with the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Records indicated that a number of staff were overdue refresher training with regard to basic first aid, management of actual or potential aggression and transport training.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a residents' directory in place that was made available to inspectors. It contained all of the information required under Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The management arrangements in place ensured the safety and quality of the service was consistent and regularly monitored. The centre was adequately resourced to meet the assessed needs of residents.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

All residents had comprehensive transition plans to support their move to the centre and all had to up date signed contracts of care.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose available did not contain details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision and, arrangements for residents to access religious services of their choice.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

From a review of incidents that had occurred in the centre since the last inspection, the person in charge had notified the Chief Inspector of Social Services in line with the regulations when an adverse incident had occurred in the centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. There was complaints procedure and there was also an easy-to-read version displayed in the centre. A review of the complaints log showed all complaints received were recorded and followed up.

Judgment: Compliant

Quality and safety

Overall, residents were being facilitated to enjoy good quality, person centred care and supports. However, there were significant improvements required in general welfare and development. Some improvement was required in relation to healthcare and positive behavioural supports.

Inspectors reviewed a sample of residents' files and found that each had their needs assessed on an annual basis or sooner if required in line with their changing needs

and circumstances. There were clear personal plans in place for any identified need which guided staff in the care to be delivered. There were arrangements in place to carry out reviews of the effectiveness of personal plans, such as a monthly checklist for when aspects of the plan were due a review.

For the most part there was regular and timely access to a range of allied health care professionals. This included access to physiotherapy, occupational therapist (OT), general practitioner (GP), and a speech and language therapist (SALT). Healthcare plans were also in place to support residents in achieving best possible health and were reviewed regularly. However, inspectors did find that in the case of one resident a healthcare referral was not followed up and they were still waiting on an appointment after several years. In another file inspectors found that while the medication protocol for one resident clearly directed staff in how to manage a specific healthcare need, the linked healthcare plan did not mention emergency rescue medication. This could result in staff particularly new staff not having consistent information and direction on how to appropriately and safely support a resident with their healthcare needs. For example one staff spoken with was not clear in relation to the frequency of dosages with regard to an emergency medication a person was prescribed in case it was needed.

Inspectors reviewed the arrangement in place to support residents' positive behaviour support needs. Residents were being supported to manage their behaviour positively with access to members of a multidisciplinary team (MDT), for example, behavioural therapist and psychologist. There were behaviour support plans in place as required and the residents had documented annual reviews carried out by the behavioural MDT support team to review their presentation and supported required, however the support plans themselves were not reviewed since 2019. This meant that staff may not have had the most up to date information required to support the residents with their positive behaviour support needs. Potentially staff could be using support methods no longer deemed appropriate for use with a resident.

Inspectors found that there were minimal restrictive practices in place, these restrictions were assessed as clinically necessary for a resident's safety and wellbeing. For example, a locked chemical press and one locked wardrobe. From a review of the restrictive practices inspectors found that they were appropriately identified and reviewed by the providers restrictive practice committee. They were last reviewed by the committee in July 2021.

Inspectors looked at the safeguarding arrangements in the centre and found that they were sufficient. There was a safeguarding policy in place and reviewed as required. From the sample of staff files viewed staff had been provided with training in safeguarding adults. Staff spoken with were familiar with the procedures to follow in the event of an incident of abuse occurring in the centre.

Residents' rights and the running of their home was promoted within the centre. Staff supported residents to practice life skills for example bringing in their washing in order to gain more independence. Residents were also being supported to be more independent and promote opportunities for privacy when completing their

personal care where possible. There was evidence of inventive ways being explored to promote this, such as a bell a resident could ring when they were finished using the bathroom. This afforded the resident opportunity for privacy and ensured that the process was not rushed and that it was taken at the resident's pace.

From a review of residents' financial management and personal possessions inspectors could see that there appeared to be appropriate oversight and safety measurements in place for residents' finances. This included a contract of care that included all fees payable by the residents, daily money balance checks, monthly financial audits and individual safes. Residents had personalised rooms with adequate storage facilities for their belongings.

The person in charge was ensuring that residents were supported with their personal and healthcare needs. However, as discussed in the opening section of this report residents had limited opportunities for engagement in leisure activities and recreation in or out of the centre. Residents were supposed to be availing of an in-house day programme but there was no evidence demonstrated to inspections through communication, observation and documentation of any meaningful way that residents spent their days. Residents were observed sitting around with nothing to do the majority of the day of inspection. They lacked opportunities for social integration and participation in the life of the community. Residents were not being assisted in finding opportunities to enrich their lives. For example, residents were not going out for coffee, meals out, they were not going into any shops and not attending any leisure activities, such as the cinema. This began when COVID-19 started and has continued since the easing of COVID-19 restrictions. Residents' goals were limited to focusing around life skills and although this is important for promoting independence it did not afford the opportunity for residents to work towards any social or recreational goals.

Inspectors carried out a walkabout of the centre and found it to be homely and all areas accessible. There were however some areas that required attention, such as minor decorating works required for some walls, doors and the sitting room ceiling that were observed by inspectors.

There were risk management arrangements in place, including a risk management policy and procedures. The centre had a risk register and a health and safety statement in place. All risks identified on the risk register had an individual risk assessment. There were individual risk assessments in place for each resident in order to support their safety and wellbeing. From viewing a sample of residents' individual risk assessments for the most part they were being reviewed regularly.

The provider had a detailed COVID-19 contingency plan which outlined the strategies in place to prevent/manage an outbreak and it was reviewed regularly. The person in charged had completed a COVID-19 self-assessment tool and it had recently been reviewed. Other local arrangements in place included a monthly infection control audit completed by the person in charge and the centre had an infection control lead in place that carried out their own audits. The centre had recently completed an infection prevention and control checklist for residential care

facilities in the context of COVID-19 in September 2021.

The provider had also ensured that systems were in place for the prevention and management of risks associated with COVID-19. Staff had been provided with training in infection prevention and control, and hand washing techniques. Personal protective equipment (PPE) was available in the centre and staff were observed using it in line with national guidelines. For example, masks were worn by staff at all times due to social distancing not being possible to maintain in the centre. There was adequate hand-washing facilities and hand sanitising gels available throughout the centre. Enhanced cleaning schedules had been implemented and staff were observed completing same. There were colour coded chopping boards, and colour coded mops and buckets in place which were stored appropriately.

Inspectors reviewed the fire precaution arrangements for the centre. There were suitable fire safety management systems in place and these included emergency lighting and signage, servicing of firefighting equipment, staff completed monthly fire inspection checklists and staff were trained in fire safety. Staff spoken with were knowledgeable of what to do in the event of a fire. Inspectors observed two fire doors not closing fully by themselves and one had a gap around the seal. This was brought to the attention of one of the senior management team on the day of inspection and was rectified by the end of the day, further information was provided by the organisations fire safety expert post inspection which provided assurances that the fire safety systems in place were appropriate to the centre.

Regulation 12: Personal possessions

Residents had personalised rooms and adequate storage facilities for their personal possessions. There were good financial management systems in place.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had limited opportunities for engagement in leisure activities and recreation in or out of the centre. They lacked opportunities for social integration and participation in the life of the community. Residents were not being assisted in finding opportunities to enrich their lives. Resident goals were limited to focusing around life skills.

Judgment: Not compliant

Regulation 17: Premises

There were some minor decorating works needed for the premises such as the painting of certain rooms, doors or ceilings.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place to manage and mitigate risk and keep residents safe in the centre. These arrangements included a risk management policy and procedure, health and safety statement, risk register and centre and individual risk assessments.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19 and healthcare associated infections. There was a detailed COVID-19 contingency plan in place. Staff were trained in infection prevention and control and hand washing techniques. The centre was observed to be clean, there was available PPE for staff use and staff were observed using it in line with national guidelines.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place and these included emergency lighting and signage, servicing of firefighting equipment, staff complete monthly fire inspection checklists and staff were trained in fire safety. Staff spoken with were knowledgeable of what to do in the event of a fire.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

From a sample of residents' files each had their needs assessed on an annual basis or sooner if required in line with their changing needs and circumstances. There were clear personal plans in place for any identified needs which guided staff. There were arrangements in place to carry out reviews of the effectiveness of personal plans.

Judgment: Compliant

Regulation 6: Health care

One resident's healthcare referral was not followed up and they were still waiting on an appointment after several years. A healthcare plan for another resident did not mention emergency rescue medication and one staff spoken with was not clear in relation to the frequency of dosages of emergency medication a person was prescribed in case needed.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

While residents did receive annual reviews by the behavioural MDT support team to review their presentation and supports required, the support plans themselves were not reviewed since 2019.

Judgment: Substantially compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse. Staff were appropriately trained and of the staff spoken with they were familiar with the procedures to follow in the event of an incident of abuse occurring in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were being promoted within the centre. Residents were being supported to become more independent with regard to the running of the centre and around their own personal care.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mullingar 5 OSV-0002760

Inspection ID: MON-0029015

Date of inspection: 28/09/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training department have prioritized the staff who require refresher training in first aid and MAPA. Staff have already completed manual handling refresher training. Training to support staff in suitable use of transport aids e.g. harnesses and clamps, is scheduled for 5th December 2021.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The statement of purpose in its current format will be updated to include details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision and, arrangements for residents to access religious services of their choice, this will be completed by 01/12/2021. A full review of the Statement of Purpose will be undertaken and a transfer of the contents to the new HIQA format by 01/02/2022	
Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development: Area Director, person in charge and key workers in consultation with the residents and their circle of support, will review goals in place. The Person In Charge will support the staff team in sourcing more opportunities within the community. The Person In charge will ensure the residents are supported to explore their interests and have further opportunities for recreation and leisure activities. The Person in Charge and staff team will actively encourage further family contact and options for socializing with their circles of support outside of the designated Centre.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Works required to redecorate the house have been highlighted to maintenance and have been scheduled.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The resident's GP has been contacted and a private healthcare referral has been requested in consultation with the resident and his family, to ensure a speedier appointment and review of treatment. An appointment date will be sourced by 01/12/2021 with a view to attending for appointment by 01/03/2022 The healthcare plan for another resident has been reviewed and clearly states, as per prescription and treatment plan, the dosage and timeframe for adminstration of emergency rescue medication. All staff have been made aware of same and have read and understand the reviewed and updated plan.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:	

The support plans have been reviewed by the behavior support team and going forward, the plans will be reviewed as part of review meetings and this will be clearly documented.

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)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	01/02/2022
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	01/02/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	01/02/2022

	as part of a continuous professional development programme.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	01/03/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	01/02/2022
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	01/03/2022
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	01/03/2022
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed	Substantially Compliant	Yellow	01/12/2021

	consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			