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:	Acorn Respite & Residential Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	07 August 2024
Centre ID:	OSV-0003914
Fieldwork ID:	MON-0043126

About the designated centre

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

Acorn Residential Services is a centre operated by Western Care Association. The centre provides residential care for up to ten male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of two houses located on the outskirts of a town in Co. Mayo, situated within close proximity to each other. Residents have their own bedroom, en-suite facilities, shared bathrooms, kitchen and dining areas, sitting rooms, staff office, utility and garden area. 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:	8

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 7 August 2024	10:00hrs to 17:00hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

This inspection was completed to monitor compliance with the regulations in line the regulatory plan in place at present, in addition the findings of this inspection will also inform a registration renewal decision which is pending. Overall, this inspection found that the provider was working on actions identified from the risk inspection completed in February 2024. The inspector found that significant progress had occurred, and the provider was working in line with their compliance plan response for the risk inspection and the regulatory programme in place. The local management team in this centre were maintaining and sustaining a good service in this centre.

This centre is run by Western Care Association in Co. Mayo. Due to concerns about the governance and oversight of Western Care Association centres and its impact on the well-being and safety of residents, the Chief Inspector of Social Services undertook a targeted safeguarding inspection programme which took place over two weeks in March 2023 and focused on Regulation 7 (positive behaviour support), regulation 8(protection), regulation 23 (governance and management) and regulation 26 (risk management procedures). The overview report of this review has been published on the HIQA website, in response to the findings of this review, Western Care Association submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure a sustained compliance with the regulations. Inspectors have commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, but also to assess whether these actions of Western Care Association have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in co. Mayo, At the time of this inspection a number of actions had been implemented, with more in progress for completion. These will be discussed under each regulation, with more in progress for completion. These will be discussed under each regulation later in the report.

The centre provided full-time residential care for five residents and respite services for three residents with one vacancy at the time of the inspection. Both houses provided suitable and comfortable living space for all residents with adequate external space for additional activities. At the time of the inspection there was five residents enjoying their summer leave from day services while planning their summer activities. One resident met the inspector and spoke at length for his plans which, included nights away with a fellow resident, enjoying music events and other activities with staff support. Other residents also had planned activities which involved days out to local places of interest and activities that were also relevant to them. The inspector noted how comfortable all residents were in the centre and they all enjoyed sitting with the inspector and staff during the inspection. In addition, the inspector noted that planning had occurred for the summer events to facilitate all remaining building work to be completed in the house without causing too much disruption for the residents.

The inspector attended the residential house and was greeted by staff on duty that morning. They notified their area manager and invited the inspector into the centre after their identification was provided. A short time later the Are manager and assistant manager attended to assist with the inspection. An opening meeting was completed and the inspector outlined the plans and regulations for review that day. The inspector found that both staff were very familiar with all residents in the centre, progress on the regulatory programme in place, and its impact on Acorn services. There were four staff separate to the managers and the inspector spoke briefly with them due to planned activities in place that day. All staff were knowledgeable, calm, professional and treated the residents with respect and dignity at all times.

The inspector completed a walk around of both houses by the person in charge and assistant manager while hearing the actions completed and the progress on the regulatory plans in place, improvements and any change in needs for all residents since the last inspection. Some changes included cognitive decline, incompatibility and review of placements. This was evident in the reconfiguration in residents in both houses and the provider had further plans in place to meet the aging needs of residents living in this centre in consultation with local housing providers. These changes were monitored by the staff team and all relevant multidisciplinary staff required. Staff spoke about residents preferences in activities, such as home based activities, day services, local music events and visiting places of interest locally.

The inspector found that both houses were suitably decorated and comfortably furnished throughout, and this was suitable to the assessed needs of the residents. Photographs and paintings and personal items were also on display throughout the centre which also included relevant information about the centre for residents and visitors that attended.The isnpector saw significant work had been completed throughout both houses, which included painting and resurfacing of flooring and replacement of some worn flooring. There was further plans after the inspection for further work due to residents summer holidays.

Following discussions with staff, observations in the centre and a review of records, the inspector found that the residents had a good quality of life, where they made choices about what to do, and were supported to be active in their local community and the management team responded to residents individual needs.

Overall, the inspector found that this service was very focused on residents care and support needs, but was also ensuring that planning was in place for the aging profile and compatibility needs in the centre, whilst working on the actions remaining in the providers regulatory programme in place. Residents were also supported to maintain contact with family members and representatives that was very person centred.

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

Capacity and capability

Overall, the inspector found that this centre was well monitored and the management team had effective oversight of this centre, which ensured that the residents received support and care in line with their assessed needs, and received a good service.

The inspector noted that governance and management arrangements in this centre had recently changed due to the organisation reconfiguring the regions and increasing the management structure and oversight. The inspector found that this newly appointed management team had settled into their roles and were very familiar with the residents and their assessed needs. Staff spoken with on the day of inspection all spoke of the positive changes for both residents since moving into the centre, but also of positive changes with the management structures and communication systems in the organisation. The inspector noted that areas for improvement in this centre related to the provider's compliance plan and ongoing actions required. These will be expanded upon later in this report.

The staffing arrangements in place were reviewed as part of the inspection. A planned and actual roster was available and it showed an accurate account of staff present at the time of the inspection. The provider ensured that the number and skill mix of staff met with the assessed needs of residents and as a result good consistency of care and support was provided.

A review of the governance arrangements showed recent changes of a new management structure in place. This was clearly defined and staff were clear about their roles and responsibilities and, therefore, the lines of authority. The person in charge and proposed person in charge were present on the day of the inspection. The inspector found that a newly proposed person in charge had worked as a staff in services and was very familiar with both residents and their needs. She was very familiar with the support needs of both residents and was undertaking additional assessments to ensure they were both monitored and supported appropriately, due to changing needs.

The annual review of the quality and safety of the service was completed and up to date, but also showed relevant actions for completion, which was linked to the provider compliance plan response. In addition, the six monthly unannounced provider-led audit was completed in the time-line required and a number of actions identified and actioned. Staffing was provided by a core team which provided consistency of care and support required in line with the residents' assessed needs. Team meetings were taking place regularly and a clear action plan was available.

Overall, the inspector found that the governance and management arrangements had significantly improved in this centre which resulted in a safe and effective service provided. This all led to good outcomes for residents quality of life and the care provided in this centre.

Registration Regulation 5: Application for registration or renewal of registration

The provider had applied to renew the registration of Acorn services, which included the prescribed information as required by the regulations and within the specified timeframe.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was reviewed and appropriate to meet the needs of residents in this centre. The inspector found that staff rosters were adapted and reviewed to meet the needs of residents, which included additional staffing to facilitate resident outings.

Judgment: Compliant

Regulation 16: Training and staff development

A review of training records showed that all staff had completed mandatory training and were also in receipt of bespoke training such as Neurodiversity and epilepsy management for example.

Judgment: Compliant

Regulation 19: Directory of residents

The inspector found that the directory of residents was available in the centre and the inspector found that improvement was required as it did not contain all of the information as specified in the regulations.

Judgment: Substantially compliant

Regulation 21: Records

Records were available for review and contained all of the required information as specified by the regulations.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured that appropriate insurance for the centre was in place.

Judgment: Compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 12 actions aimed at improving governance and management arrangements at the centre. The provider aimed to have all actions completed by 31/01/2024. At the time of the inspection eight actions had been implemented with the remainder in progress.

Completed actions included an assessment of the senior and frontline management structures and the reconfiguration of service areas, the establishment of a new incident monitoring and oversight committee and a reinstated human rights committee, and the introduction of new arrangements for unannounced provider visits. In addition, a standardised monthly report writing template was introduced to the service and regulatory information events were provided for staff.

The inspector found that the remaining four actions were commenced and were progressing. The quality, safety and service improvement department were finalising the review of service audits. The governance and quality improvement framework was in draft form and under review. A training and development project group was established and they had selected an information system which would enhance and support the staff training arrangements in place. This included a review of the policy, procedures and guidelines which were not yet established or embedded into the organisation.

It was clear that the management team was very well informed of the ongoing actions taken by the provider to strengthen the governance and management arrangements in this centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had ensured that the statement of purpose included some of the information required by the regulations and adequately described the service and was also provided in an accessible format but improvements were required in the floor plans and room descriptions.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that the service provided in Acorn respite and residential services ensured that residents living in the centre received care and support which was a very good quality, person-centred and which promoted their wellbeing, and enabled residents to be active participants in their local community.

Residents had access to the local community and were also involved in activities that they enjoyed as well as home based activities in the centre. There were a variety of amenities and facilities in the surrounding areas. Transport and staff support was available to ensure that these could be accessed by residents. Residents receive support from residential staff and support from day service staff in programmes they attend in the region.

Review meetings took place annually, at which both residents' support for the upcoming year were planned. This ensured that residents' social, health and development needs or age appropriate needs were identified and that the relevant supports were put in place to ensure these were met. At the time of the inspection, the inspector saw that residents' needs were under review due to changes in their assessed needs but the staff and management were continuously assessing and monitoring the residents' needs. The plans viewed during the inspection were up to date and were clearly recorded with all relevant information.

Both houses were located in close proximity on the outskirts of a large town. The centre was spacious, clean, comfortably furnished and decorated throughout, suitably equipped and very well maintained. The inspector noted that residents had personalised their home throughout. This included pictures, photographs of friends and family, and ornaments. Residents had their own bedroom, bathroom facilities, and access to communal sitting room and dining area and a kitchen and staff office and sleepover room in the centre. There was also external space in garden areas available for residents.

The inspector completed a walk-around of both houses and reviewed actions from the previous inspection. It was noted that significant work was completed which included the removal of the outside boiler house that was in close proximity to the

centre, painting throughout, improved flooring throughout with plans for further work during the resident's summer holidays. Overall, the inspector found that both houses were very comfortable, suitably decorated and that the residents were very comfortable and familiar with their homes.

At this centre, the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies. Policies on risk management were available for review and safety statements were up to date. Risk assessments for service level risks were in place and each resident had a personal risk management plan.

Following the last inspection, the provider completed a significant review of fire safety in one house in the centre to ensure effective fire precaution systems were in place, including removal of highlighted actions from external reports such as removal of a boiler house. Assurances were also received from the organisations fire reports confirming that all required work was completed and addressed following the inspection. The inspector was shown the work completed by the person in charge during the inspection and found that it was satisfactory.

In summary, residents at this designated centre were provided were provided with a good quality service where their independence and autonomy was promoted. There were good governance and management arrangements in the centre which led to improved outcomes for residents' quality of life and care provided. Ongoing actions committed to by the provider on their compliance plan would further enhance the service and the quality of the care and support provided.

Regulation 12: Personal possessions

A record was kept of residents' personal possessions and valuables, which was maintained and monitored by the staff team.

Judgment: Compliant

Regulation 17: Premises

Overall, the two houses met the requirements of schedule six, and the provider had completed some actions identified in the February inspection and were working on two further actions at the time of the inspection. This included refurbishment of a main bathroom and kitchen in one house in the centre.

Judgment: Substantially compliant

Regulation 20: Information for residents

The provider had a residents guide in place which showed all information as specified in the regulations and it was also available in an accessible format.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The provider had a policy and procedures in place for the temporary absence, transition, and discharge of residents in the centre. At the time of the inspection, no residents required these procedures.

Judgment: Compliant

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete three actions aimed at improving risk management arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection two actions were completed and one was in progress.

Actions completed included a review of the risk management policy and the introduction of a quarterly process of incident review.

The inspector found that one action in relation to incident management training was in progress.

In this centre, the inspector found good systems in place for the assessment, management and ongoing review of risk, including a system to responding to emergencies, policies on risk management were available for review and safety statements were up to date. Risk assessments for service level risks were in place and each resident had a personal risk management plan.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Following the last inspection, the provider had ensured that the actions identified were completed. This included removal of the boiler house which was close to one house in the centre, a review of all fire doors, fixtures and fittings and confirmation from a competent person the service met the requirements of fire safety guidelines and regulations.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving behaviour support arrangements at the centre. The provider aimed to have all actions completed by 30/06/2024. At the time of the inspection the provider had completed six of these actions. The seventh action had commenced and was in progress.

Completed actions included the appointment of an interim head of clinical and community support and the appointment of additional multi-disciplinary supports. Under the leaderships of the psychology team, a governance and clinical oversight group was established in order to co-ordinate the response to critical incidents. A review of the role and function of the psychology team was completed and guidance on referral pathways was developed.

The inspector found that one action remained in progress. The training module in neurodiversity was developed, a pilot was completed and that full roll out of the training module had commenced with management and some staff at the time of the inspection.

In this centre, the inspector found that residents that required support with positive behaviour support had access to specialist supports. The policy on behaviour support was up to date and staff training was provided.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving safeguarding arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection all actions were completed.

These included the establishment of a safeguarding oversight committee, updating of the provider's safeguarding and protection policy and the introduction of a six

monthly review for open safeguarding plans. In addition, staff had access to face to face training in safeguarding and protection and new systems were in place to improve staff awareness of the contents and actions of open safeguarding plans where required.

At this centre, the inspector found that residents were supported to understand the need for self-care and protection. If safeguarding plans were in place, the inspector noted that the staff and management team had a good awareness of the plans requirements and that the actions were integrated into the behaviour support strategies and personal risk management plans.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Acorn Respite & Residential Services OSV-0003914

Inspection ID: MON-0043126

Date of inspection: 07/08/2024

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of Residents is updated to reflect the required information.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has restructured the Senior Management team to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management, and oversight. Under the remit of the HSE's Service Improvement Team the Models of Service sub-group has been merged as part of the Quality, Safety and Service Improvement workstream. The Provider has devised a schedule of unannounced visits to commence in mid-September 2024. The bi-annual thematic governance and quality improvement report was completed and circulated to the Senior Management Team on 12th August. A learning management system pilot has commenced in two service areas for staff training and development and aims to implement the system to the rest of the organisation by the end of the year. The provider continues to facilitate monthly staff regulatory events. The quarterly properties and facilities plan is presented at senior management for oversight with regard to its monitoring and implementation. An organisational report is submitted to the provider from the senior management team	

through the Chief Executive Officer every 2 months. A fortnightly Huddle takes place with updates on actions from: CEO; QSSI, HR, Operations, Properties and Facilities, Finance and others as required. This is communicated across the organisation through a flyer document. The provider has submitted a business case to the commissioner of services to strengthen the current on-call arrangement. An Organisational On Call Arrangement to be implemented in Q4 2024. Currently stakeholder engagement is ongoing, implementation phase will commence as soon as stakeholder engagement has been completed.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Person in Charge has updated the Statement of Purpose with room descriptions inline with the floor plan.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: A time bound plan is in place to finalise all actions identified as requiring improvements in the DCD premises. The main bathroom had works completed on the 16.08.2024. Recommendations from a 'mould specialist' are ongoing with all actions to be completed by 30/10/2024. The kitchen and utility will be replaced by 30/11/2024. Painting throughout the service will be concluded on the 30/11/2024.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports. The training module on the revised incident management framework policy commenced on the 15/05/ 2024. The risk management policy and associated training module are in consultation stage with various stakeholders for organisational implementation. The Risk Management Framework will be presented to the QSSI workstream for stakeholder engagement. Following consultation, a draft framework and training module was presented to the Senior Management Team on 20/08/24. A codesign of the module and policy with the Senior Operations Team and Frontline Managers will be undertaken by the week of 30/09/24. The pilot project commenced on 31/07/24 which will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review. The audits will be presented to the PIC forum on 16/09/24.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Governance and Clinical oversight Group has been renamed as the Critical Response Team and meets on a quarterly basis. The Neurodiversity training module commenced and is being rolled out to all staff in the organisation with refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and the Listening and Responding Policy has been reviewed and will be considered by key stakeholders including the Chairperson of the Rights Review Committee. The Inter Clinical Team Working policy will be implemented once the Clinical Lead has commenced in their position.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/11/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	06/09/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2025
Regulation 26(2)	The registered	Substantially	Yellow	31/01/2025

	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.	Compliant		
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	06/09/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/11/2024