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:	Dun Aoibhinn Services Cahir
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Announced
Date of inspection:	16 November 2022
Centre ID:	OSV-0005066
Fieldwork ID:	MON-0029228

About the designated centre

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

Dun Aoibhinn Services Cahir is a designated centre operated by Brothers of Charity Services Ireland CLG. The designated centre provides a community residential service for up to four adults with a disability. The service also caters for those with additional support needs such as mental health diagnoses, Autism Spectrum Disorder and associated behaviour support needs. The designated centre is a large detached two storey house in a rural setting within a short driving distance of local towns. The designated centre comprises of four individual resident bedrooms (two of which were en-suite), staff bedroom, office, shared bathroom, sensory room, sitting room, utility room and an open plan living, dining and kitchen area. There is a private garden to the rear of the premises for residents to avail of as they please. The centre is staffed by the person in charge, staff nurse, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 16 November 2022	09:30hrs to 18:00hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This was an announced inspection conducted to monitor on-going compliance with the regulations and to inform the renewal of registration decision. This inspection took place when precautions relating to the COVID-19 pandemic were still required. As such, the inspector followed public health guidance and Health Information and Quality Authority (HIQA) enhanced COVID-19 inspection methodology at all times. The inspector ensured physical distancing measures and the use of personal protective equipment (PPE) were implemented during interactions with the residents, staff team and management over the course of this inspection.

The inspector had the opportunity to meet three of the residents over the course of the inspection. One resident was attending their day service followed by a planned stay at home in line with their personal plan.

On arrival, the three residents were preparing for the day in the open plan dining/sitting room of the centre. The inspector observed residents having tea and relaxing watching television. Later in the morning, the inspector observed residents being supported to walk in the local area. In the afternoon, residents were supported to have lunch and access the local community. The residents communicated in a variety of ways. Some residents used alternative and augmented communication methods to communicate. The inspector gauged the residents satisfaction with the service that was provided through observation, speaking with staff supporting residents, representative questionnaires and reviewing residents files. On the day of inspection, the inspector observed that residents appeared content and comfortable in the centre. However, the staffing arrangements in the centre were observed to be impacting on the lived experiences of residents. For example, the provider had self-identified the need for additional staffing for one resident. On the day of the inspection, the inspector observed the staff team co-ordinating resources and all resident activities outside of the centre in order to ensure that one resident's assessed needs could be met in a safe manner. The improvements required in the staffing levels were also identified on the previous inspection.

As noted, the house consisted of four individual resident bedrooms (two of which were en-suite), staff bedroom, office, shared bathroom, sensory room, sitting room, utility room and an open plan living, dining and kitchen area. Overall, the house was observed to be well-maintained. The bedrooms were observed to be personalised and decorated in line with residents' preferences and tastes. Some residents preferred a minimalistic environment and this was catered for in their bedrooms. There was a private garden to the rear of the premises which contained equipment such as a poly-tunnel and a trampoline.

However, some areas required attention including potholes present in the gravel surrounding the centre which presented a hazard to residents and accessibility issues for one resident with limited mobility. A fence surrounding the property also

required attention. These issues were identified at the last inspection and remained ongoing at the time of this inspection. On the day of the inspection, the inspector also observed a hole in the sensory room ceiling which had been caused by a leak. This had been self-identified by the provider and plans were in place to address same.

The inspector also reviewed four questionnaires completed by residents' representatives describing their views of the care and support provided in the centre. Overall, some of the questionnaires contained positive views and indicated a level of satisfaction with many aspects of service in the centre such as activities, bedrooms, meals and the staff who supported the residents. However, one questionnaire noted concerns in a number of areas including participation in activities outside the centre, staffing and previous concerns regarding the safety of care provided to their family member.

Overall, the residents appeared content and comfortable in their home and the staff team were observed supporting the residents in an appropriate and caring manner. However, there were areas for significant improvement identified including staffing arrangements, fire safety, assessment of needs and residents rights. In addition, some improvements were required with infection prevention and control practices and the premises.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, there was a clearly defined management system in place which strived to ensure that the service provided was safe, consistent and appropriate to residents' needs. However, the staffing levels required significant improvement as they were negatively impacting on the quality of life of some residents in the centre. In addition, improvement was required in the training and development of the staff team.

Overall, the provider had not ensured that there was sufficient staffing levels in the centre to meet the assessed needs of residents at all times. For example, it was identified that one resident who was supported during the day on a one-to-one basis required the assistance of two staff to assist with activities of daily living including personal care and mobilising. This second staff member was deployed, for the most part, from the other residents' assigned staffing. At times, in the event that a second resident's staffing was not in the centre, the resident could have to wait for staff to return to the centre or be redeployed from other services in order to have their needs attended to. This meant that the staffing levels in place were not in line with this resident's needs and negatively impacted on all residents choice,

dignity and rights. This issue was also identified in the previous inspection.

The centre was managed by a full-time, suitably qualified and experienced person in charge. There was evidence of regular quality assurance audits taking place to ensure the service provided was monitored. These audits included the annual review for 2022 and the provider's unannounced six-monthly visits. These quality assurance audits identified areas for improvement and action plans were developed in response. However, improvement was required to ensure the designated centre was appropriately resourced to ensure the effective delivery of care and support.

There were systems in place for the training and development of the staff team. From a review of a sample of training records, it was evident that for the most part the staff team in the centre had up-to-date training. However, improvement was required as not all staff had up-to-date training in de-escalation and intervention techniques. This meant that not all of the staff team had up-to-date skills and knowledge to support residents with identified needs.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time, suitably qualified and experienced person in charge to the centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had not ensured that there was sufficient staffing levels in the centre to meet the assessed needs of residents at all times. This was also identified as an area for improvement on the previous inspection.

The staffing requirements in this centre were high due to the assessed needs of the residents and each resident had assigned staffing support in line with their assessed needs. However, one resident who was receiving one-to-one support was assessed as requiring two-to-one support for significant parts of the day to assist with

activities of daily living including personal care, mobilising and accessing the community. This second staff member was generally deployed from the other residents' assigned staffing. Overall, the staffing levels in place negatively impacted on this residents' choice, dignity and rights as they relied on other residents' assigned staffing to complete activities including personal care. As noted, at times, in the event that a second staff was not in the centre, the resident could have to wait for staff to return to the centre or be redeployed from other services in order to have their personal care needs attended to.

In addition, the current arrangements in place of the staffing resources also meant that there was a negative impact on the other three residents' activities, choice and access to their assigned staff supports. For example, the other residents would complete activities close to centre or in the centre as their assigned staffing supports may be required to support the other resident.

The inspector was informed that an application had been submitted to the provider's funder for additional staffing. However, the issue remained ongoing at the time of the inspection.

The person in charge maintained a planned and actual roster. The inspector reviewed a sample of the roster and found that there was a core staff team in place which ensured a level of continuity of care and support to residents. At the time of the inspection, the centre was operating with five whole time equivalent vacancies which was managed through the current staff team and use of agency and relief staff. The inspector was informed that the provider was in advanced stages of the recruitment process to fill these vacancies. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner.The inspector reviewed a sample of staff files and found that they contained all of the information as required by Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of a sample of training records, the majority of the staff team had up-to-date training in areas including infection control, fire safety and safeguarding. However, a number of staff required training and refresher training in de-escalation and intervention techniques as it was identified as a control in managing identified risks in the centre. This meant that not all of the staff team had up to date skills and knowledge to meet the residents needs. This had been self-identified by the person in charge and plans were in place to address same.

A clear staff supervision system was in place and the staff team in this centre took part in formal supervision. The inspector reviewed a sample of the supervision records which demonstrated that the staff team received supervision in line with the

provider's policy. The staff team spoke positively of the support they received.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider maintained a directory of residents in the designated centre which contained all of the information as required by Schedule 3 of the regulations.

Judgment: Compliant

Regulation 22: Insurance

There was written confirmation that valid insurance was in place including injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The person in charge reported to the Services Manager, who in turn reported to the Regional Services Manager. There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to the resident's needs. The quality assurance audits included the annual review 2022 and six monthly provider visits. In addition, there was evidence of local quality assurances audits were taking place which included infection prevention and control. These audits identified areas for improvement and developed action plans in response.

However, improvement was required to ensure the designated centre was appropriately resourced to ensure the effective delivery of care and support. For example, the staffing levels in place were not sufficient to meet all of the residents' assessed health, personal and social care needs. This had a negative impact on the lived experience of residents. This is outlined in more detail under Regulation 9: Residents Rights and Regulation 15: Staffing. This was also identified as an area for improvement at the last inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose and function for the designated centre. The statement of purpose and function contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of adverse accidents and incidents occurring in the designated centre and found that the Chief Inspector of Social Services was notified as required by Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the inspector found that this centre was a comfortable home which strived to provide person-centred care. However, significant improvement were required in assessment of needs and residents rights. In addition, some improvement were required in fire safety, risk management, the premises and infection control practices.

The inspector reviewed a sample of residents' personal files which comprised of a comprehensive assessment of residents' personal, social and health needs. Personal support plans reviewed were found to be up-to-date and to suitably guide the staff team in supporting the residents with their personal, social and health needs. However, the arrangements in place based on the assessment of needs required review.

There were positive behaviour supports in place to support residents manage their behaviour. Behaviour management guidelines were in place as required. The inspector reviewed a sample of these guidelines and found that they were up to date and appropriately guided the staff team. There were restrictive practices in use in the centre. The restrictive practices were appropriately identified and reviewed by the provider.

There were systems in place for fire safety management. However, night time drills did not demonstrate that all persons could be safely evacuated in the event of a fire.

Regulation 17: Premises

The designated centre was decorated in a homely manner and well-maintained. The previous inspection found that some improvement was required in the maintenance of the centre including a number of pot holes in the driveway and a fence in need of maintenance. This issues remained ongoing at the time of this inspection. In addition, the inspector observed a hole in the ceiling of the sensory room caused by a leak which required repair.

Judgment: Substantially compliant

Regulation 20: Information for residents

The provider a residents' guide in place which contained all of the information as required by Regulation 20.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. Risks were managed and reviewed through a centre specific risk register and individual risk assessments. The risk register outlined the controls in place to mitigate the risks.

However, some controls outlined to manage identified risks required review to ensure they were in place, accurate and up-to-date. For example, a number of staff were not up to date in de-escalation and intervention techniques training. In addition, one residents individual risk assessments identified two-to-one staffing supports as a control measure to manage identified risks for a resident with one-to-one staffing supports.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19 in

relation to staffing and the self-isolation of the residents. Staff were observed wearing PPE as appropriate throughout the day of inspection. Cleaning schedules were in place and the inspector observed that the centre was visibly clean on the day of the inspection.

However, the storage of cleaning equipment required review. The inspector observed mops stored externally and buckets stored with residue at the bottom. This practice did not ensure that buckets and mops were stored in a manner that kept them clean and reduced the risks of contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. There was evidence of regular fire evacuation drills taking place.

However, night time drills did not demonstrate that all persons would be safely evacuated in the event of a fire. For example, at night-time the four residents were supported by one staff member on a waking night shift and one member of staff on a sleep over shift. Some residents were assessed as requiring some additional support due to their mobility needs. The last night time drill undertaken in November 2022 was carried out at 20:50 and did not demonstrate that the night time evacuation arrangements were appropriate.

Each resident had a personal evacuation plan in place. However, the guidance required review to ensure the staff team were appropriately guided to support residents to evacuate in the event of a fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was appropriate systems and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines. There was a locked cabinet in the centre for the storage of medications. Medication administration records were in place and being completed appropriately by staff. Medications were appropriately labelled and liquid medications, creams and lotions were clearly marked with the date they had been opened.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the a sample of residents' personal files. Each resident had a comprehensive assessment which identified the resident's health, social and personal needs. The assessment informed the resident's personal plans which guided the staff team in supporting resident's with identified needs, supports and goals.

However, the arrangements in place to meet the needs of each resident required significant improvement. For example, there was one recent change in needs which lead to an emergency admission to hospital. A number of the staff team spoken with noted their concern in relation to the supports in place for this resident. This meant further assessments were required to ensure appropriate arrangements were in place to meet the resident's needs. This had been self-identified by the provider and there was evidence that the provider was taking action to address same. However, on the day of the inspection this issue remained ongoing.

Judgment: Not compliant

Regulation 6: Health care

The residents' health care supports had been appropriately identified and assessed. The inspector reviewed health care plans and found that they appropriately guided the staff team in supporting the residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' were supported to manage their behaviours and positive behaviour support guidelines were in place, as required. Residents were supported to access psychology and psychiatry as required,

There were systems in place to identify, manage and review the use of restrictive practices. There were a number of restrictive practices in use in the designated centre which had been appropriately identified as restrictive practices and reviewed by the organisation's restrictive practice committee.

Judgment: Compliant

Regulation 8: Protection

Notwithstanding, the concerns in relation to staffing levels, residents rights and assessment of need which is discussed under Regulation 15, Regulation 9 and Regulation 5, respectively, the provider had systems in place to safeguard residents.

There was evidence that incidents were appropriately reviewed, managed and responded to. Safeguarding plans were developed for identified concerns and it was evident that appropriate actions were taken where required. The residents were observed to appear comfortable in their home. The staff team demonstrated good knowledge of how to identify a concern and the steps to take in the event of a concern.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that improvement was required in ensuring residents' had the freedom to exercise choice and control in his or her daily life.

For example, as noted under Regulation 15: Staffing, the staffing levels negatively impacted on one residents' dignity and control in their daily life as they relied on other residents assigned staffing to complete activities of daily living. Also, the staffing levels at times limited the choices of the other three residents as their assigned staffing supports may be required to support the other resident. This was also identified at the time of the last inspection and this issue remained ongoing at the time of the inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Dun Aoibhinn Services Cahir OSV-0005066

Inspection ID: MON-0029228

Date of inspection: 16/11/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • From the 5 vacancies identified at the time of the inspection: o 3 positions are in the final stages of onboarding recruited staff o Interviews are being scheduled for remaining positions/vacancies (2) o One Relief staff has been recruited for the service area which will reduce some dependency on agency staff use • An additional 36 hours per week has been allocated to one resident in line with their assessed needs. • The PIC continues to plan and prioritize the scheduling of staffing including the rostering of regular/familiar agency staff to ensure consistency in the delivery of care and support to residents.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Dates for the identified outstanding training have been scheduled for January 2023.	
Regulation 23: Governance and	Not Compliant

management	
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The registered provider has allocated an additional 36 hours per week to one resident to address their assessed needs and PIC will continue to plan and maximise available resources in an effort to ensure that there is no negative impact on the lived experience of residents.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A request for the identified premises works that are required has been identified with the Landlord for completion.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Risk assessments and management plans will be reviewed in the centre • An additional 36 hours per week has been allocated to one resident in line with their assessed needs and the PIC will to plan to maximise available resources in an effort to manage identified risk.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • A review of the storage of mops has been undertaken • An additional storage unit has been purchased and is scheduled to be assembled for the appropriate storage of mops and buckets.	

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Since the time of the inspection, a further nighttime fire drill has been undertaken. Learning and actions from this drill have been reviewed with the staff team and with the organisation's facilities manager. Required follow up actions from this drill are in the process of being implemented.
• All individuals PEEPs have been reviewed and are subject to regular review
• An external Consultant Engineer has been engaged by the services to assess and advise on the evacuation procedure and PEEPS for residents

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• MDT reviews are ongoing to review the changing needs of one resident. A road map of care has been identified providing clear guidance to support staff.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• An additional 36 hours per week has been allocated to one resident in line with their assessed needs and the PIC will continue to plan and maximise available resources in an effort to ensure the choice of all residents is facilitated.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/04/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	15/01/2023
Regulation 17(1)(b)	The registered provider shall	Substantially Compliant	Yellow	28/02/2023

	ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/04/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and	Substantially Compliant	Yellow	31/12/2022

	control of healthcare associated infections published by the Authority.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	31/01/2023
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	18/11/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/04/2023