Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	Woodbrook Lodge
Name of provider:	MMC Children's Services Limited
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	11 April 2023
Centre ID:	OSV-0008012
Fieldwork ID:	MON-0039297

About the designated centre

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

Woodbrook is a residential centre which can provide medium to long-term care for four residents under 18 years of age, who present with complex physical and emotional needs. Woodbrook is a large detached two-story house in a quiet countryside setting on the outskirts of a town in Co Monaghan. It comprises 4 large bedrooms, living space, kitchen, sunroom, utility room and sitting room. It also has an internal lift allowing residents in wheelchairs to access the 1st floor. The residents receive support on a twenty-four-hour basis and are supported to engage in activities in nearby towns.

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 (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 11 April 2023	10:30hrs to 15:30hrs	Eoin O'Byrne	Lead
Tuesday 11 April 2023	10:30hrs to 15:30hrs	Florence Farrelly	Lead

What residents told us and what inspectors observed

Inspectors had the opportunity to interact with all three residents. The residents were on their midterm break from school. On arrival at the residents' home, one of the residents was relaxing in their bedroom, one was listening to music, and another was watching tv.

Residents received one-to-one support from staff members, and there was an additional staff present to ensure their needs were met regarding transfers. The four staff members on duty spoke with the inspectors during the course of the inspection. The residents appeared happy in their interactions with the staff members. The residents' communication needs meant that they could not inform the inspectors' of their views on the quality and safety of the service. However, they were observed to be in good spirits and content in the company of the staff. The staff members were also observed to interact with the residents warmly throughout the inspection.

Reconfiguration of the residents' home had taken place in recent months, and the changes were based on the needs of the residents. Inspectors observed the environment to be clean and well-maintained. Residents had their own bedrooms. These were large and decorated to the preferred tastes of each resident.

An inspector reviewed a sample of residents' records and found that they were attending education, and a transfer for one resident to a school near their home was in progress. The resident had visited their new school and was due to start attending the school after the Easter holidays.

Individual work sessions were completed with residents regularly. These focused on residents' engaging in activities in and outside their home. For example a resident had been supported to celebrate their recent birthday with their peers and staff by having a party in their home. Residents were supported to go shopping with staff, and the staff team encouraged them to make choices in an attempt to develop independence. There was evidence of residents maintaining links with family members; some residents went to visit family away from their home, whereas others entertained visitors in their home.

This inspection was focused on the actions identified in a previous inspection from January 2023. The findings demonstrated that improvements had been made following the January inspection. However, there were still a number of areas where modifications were required to ensure that all areas complied with the regulations. Inspectors found that enhancements were required regarding positive behaviour support for a resident, the management of restrictive practices for residents, ensuring that staff training was up-to-date, that staff members were knowledgeable of fire evacuation procedures and that care plans regarding a resident's needs were clear and known by the staff team. Inspectors also found that infection prevention

and control (IPC) measures were lacking in some areas and needed to be improved.

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

Capacity and capability

This was the second inspection in this service this year, the previous inspection was completed on the 25.01.23. Eleven regulations were reviewed at that time, eight regulations were found to be non-compliant, three were sub-compliant, and one was compliant. Following the inspection the Health Information and Quality Authority (HIQA) had significant concerns regarding the safety and welfare of residents and the quality of the service being provided.

Many of the non-compliance's identified stemmed from an issue regarding the lift used to transport residents from the ground to the first floor of their home being out of order for a significant period. Two of the residents' bedrooms were on the first floor of their home and due to the issue with the lift, they were confined to the first floor. This meant that, the residents could not leave their home, attend school or attend required medical appointments.

The inspector issued an urgent action requiring the provider to submit assurances on how they would address the issue. Following the inspection, a warning meeting was held and a warning letter was issued which required the provider to come into compliance with the identified regulations by the 31.03.2023. The provider submitted a compliance plan regarding the inspection and also a response to the warning letter on how they would ensure that the service provided to the resident would come back into compliance with the regulations.

This inspection focused on assessing the provider's progress in responding to the actions identified in the previous inspection.

The provider had recently reconfigured the residents home, two of the residents bedrooms were moved downstairs, the lift was repaired and a service level agreement had been put in place to ensure the lift was serviced and maintained in good working order.

This inspection found that the provider, as per their compliance plan, had made several improvements to the service provided to the three residents. However, while improvements had been made, there were some areas where improvements were required, these issues will be discussed in more detail later in the report.

The inspectors noted that improvements had been made regarding the governance and management of the service however, the oversight of some practices required

attention. These included infection prevention and control (IPC) practices, staff knowledge regarding the safe evacuation of residents in the event of a fire and also their knowledge of some support plans for residents.

A person in charge was responsible for this and one other centre under the providers remit, they split their time between both centres. The person in charge was not in the centre on the day of inspection and the inspection was facilitated by the deputy manager who was fully aware of the reporting structure and the systems in place to monitor and improve the service provided. Inspectors found that while some areas required improvement, the service provided to the group of residents was to a high standard.

A monthly governance report was completed that reviewed the service provided. An inspector reviewed a sample of these, found them to be detailed, and identified most areas that required improvement. Inspectors did note that, the monthly reports had not recognised some required improvements but that, overall, it was an effective tool in ensuring the service was monitored.

Inspectors reviewed the staffing arrangements and found that safe staffing levels were maintained. The number and skill mix of staff was appropriate, and improvements had been made regarding the stability of the team and the continuity of care provided to the residents.

The training needs of the staff team were studied, inspectors found that there were deficits in some staff members training regarding areas such as; the management of challenging behaviours, medication management, Percutaneous Endoscopic Gastrostomy (PEG) feed training and epilepsy management training. This posed a potential risk and identified that there were still improvements required regarding monitoring the service.

Regulation 14: Persons in charge

The provider had appointed a full time person in charge who divided their time between this and another centre under the providers remit.

The person in charge was a qualified professional with the knowledge, experience and expertise to fulfil the post of person in charge.

The person in charge was not present for the inspection but the provider had adequate arrangements in place to ensure the centre was supported by a deputy manager who facilitated the inspection. This person demonstrated that, they were aware of their responsibilities in the absence of the nominated person in charge, could access all the required information and knew the residents well.

Judgment: Compliant

Regulation 15: Staffing

An inspector assessed the staffing arrangements. The inspector found that safe staffing levels were maintained and that the number and skill mix of the staff team were appropriate in meeting the needs of the residents.

During a multi disciplinary team (MDT) assessment on 28.03.2023, it was determined that nursing support was required for one resident. The provider was engaging in a recruitment drive to fulfil the role and in the interim staff were delivering the required care to the resident.

Judgment: Compliant

Regulation 16: Training and staff development

One of the inspectors reviewed the training needs of the staff team and found there were gaps in training in areas including, positive behavioural support management, medication management, epilepsy and PEG feeding training.

In addition there were improvements required to ensure that the training needs of staff members were appropriately tracked and responded to. The inspector notes that some training dates were scheduled, but improvements were still required.

The provider and the person in charge ensured that the staff team received monthly supervision.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. A deputy manager supported the person in charge and was based full-time in this service, they were responsible for the day-to-day running and oversight of the service. Inspectors found that, for the most part, adequate systems were in place to monitor and ensure that the best possible service was provided to each resident. However, as noted above, some areas were not compliant with the regulations, including oversight and management of IPC practices, positive behavioural supports and restrictive practice management. Improvements were required to ensure that these and other issues were identified by the providers internal auditing system and there were actions in place to address any deficits identified.

The provider had a system in place where a monthly governance report was

completed. The review of these showed that the care and support needs of the residents were under close review. Actions arose from the reviews, and there was evidence of the staff team responding to them.

There were monthly social care leader meetings and monthly team meetings with all staff. The person in charge was sharing information with the staff team. Inspectors did find that there were some improvements regarding the performance management of staff. During the day, inspectors interacted with all four staff members on duty and found there were inconsistencies regarding the staff members' knowledge. Some staff were able to give clear and accurate responses to questions, in contrast, others gave limited or incorrect answers regarding topics such as fire evacuation procedures and a feeding protocol for a resident if they presented as unwell.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose that contained the required information in Schedule 1 of the regulations. The inspector found that the statement of purpose accurately reflected the service being provided to the group of residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge and the deputy manager were submitting the required notifications as per the regulations.

Judgment: Compliant

Quality and safety

As mentioned earlier, this inspection found that improvements had been made regarding the service provided to the residents. The inspectors found that residents' health and social care needs had been assessed. The residents received person-centred care, and individualised supports were developed for them. These were under regular review and reflected the changing needs of residents. Improvements were required regarding a support plan for a resident and the staff member's knowledge of the plan. This was brought to the attention of the deputy manager,

who began improving the plan during the inspection.

A system was in place where incidents of behaviours of concerns were recorded, records viewed showed that, there had been a high number of recordings in March and one of the inspectors reviewed the January and February recordings to compare the findings. The February recordings were not available for review and the January recordings, compared to the March recordings, showed that there had been a significant increase in these behaviours. There was limited information on whether an investigation into what was causing the increase in behaviours had been completed, furthermore, the support plan which keyworkers had devised required improvement to ensure all appropriate care and management of these incidents was in place.

An appraisal of restrictive practices was also completed. An inspector found that there was no rationale for the use of bed rails as a restrictive practice. The deputy manager explained that bedrails were required, but the Occupational Therapist (OT) had declined to prescribe them as a restrictive practice. The provider continued using the bedrails without completing assessments to show that the bedrails were necessary despite listing them as a restrictive practice

The inspectors found that IPC practices were part of the staff team's daily activities. An inspector reviewed the IPC practices and arrangements and found a number of areas that required improvement, including the cleaning of vehicles used by residents and the temperature management of a fridge used to store residents' medication. Inspectors did find that the residents' home was clean and well-maintained. As mentioned earlier, it had recently been adapted and suited the needs of the residents.

The provider had ensured adequate fire safety management systems were in place. Fire detection and containment measures were appropriate. An inspector found that improvements were required to staff members' knowledge of evacuating residents from the first floor of their home. Regular fire drills had occurred, but some staff members had gaps in knowledge regarding safe evacuation.

An appraisal of risk management procedures was completed. An inspector found that improvements had been made regarding the monitoring and response to risk in the service. A risk register was in place, which was under regular review and individual risk assessments had been established for residents.

In summary, the inspection found that the provider had significantly improved the service provided to residents compared to the findings from the January inspection. Residents were receiving a better service, and the reconfiguration of their home had been completed. While positive steps had been taken, this inspection found that enhancements were still required to ensure that the service provided to residents met their needs and were in compliance with the regulations and standards.

Regulation 13: General welfare and development

Inspectors found that all three residents were attending an educational programme. As mentioned earlier, a new school placement had recently been sourced for a resident. They were due to commence it in the coming week. Residents were also encouraged to be active decision-makers in their daily routines.

Residents were also supported to maintain links with their families and were engaged in a program of activities suited to their needs.

Judgment: Compliant

Regulation 17: Premises

The provider had carried out the required modifications to the residents' home. The lift was in working order and there were arrangements to ensure that this was maintained. The premises was clean and laid out in a manner that suited the needs of the residents. The residents home as also kept in a good state of repair externally and internally.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had ensured that there were systems for the assessment, management and ongoing risk review, including systems for responding to emergencies.

The provider had also developed a risk register that captured environmental and social risks. This register was under regular review by the deputy manager, and the control measures were found to be proportionate to the identified risks. Individual risk assessments were in place for residents, and these were under regular review.

Judgment: Compliant

Regulation 27: Protection against infection

While some good practice in relation to IPC practices were identified for example cleaning records maintained, equipment begin cleaned regularly, hand sanitising facilities begin available throughout the centre, improvements were required in relation to some practices.

An appraisal of the temperature recordings for the medication fridge found that,

temperature checks were not being consistently recorded and the temperatures recorded were on occasion above the required level. Inspectors saw that, three antibiotics were stored in this fridge which posed a risk to residents being administered these antibiotics as they had not been stored at the correct temperature. The inspector also found that the fridge was stored on an uneven surface which may have been causing the high-temperature readings.

The main house fridge was reviewed, and it was found that cooked and uncooked food was stored in the same part of the fridge, posing a risk of cross contamination.

Each resident had their own vehicle. It was found that they were visibly dirty and used PPE masks were sitting on the passenger seats of two of the cars. This did not reflect appropriate practice. There was damage to the roof of one of the vehicles where a resident had pulled down a piece of the vehicle's interior ceiling and foam was visible. This area could not be appropriately cleaned and posed a potential risk to the resident using the vehicle.

Judgment: Not compliant

Regulation 28: Fire precautions

Staff had been provided with fire safety awareness training and demonstrated to the inspectors how residents would be evacuated from the centre using the evacuation chair purchased following the last inspection.

However, not all staff spoken with could identify how residents could be evacuated from the first floor safely in the event of an outbreak of fire. This required review to ensure that residents could be evacuated safely.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Inspectors found that there had been improvements regarding the service provided to residents, their needs had been assessed and for the most part, their needs were being met.

However, inspectors found that improvements were required in relation to one of the resident's who had a history of presenting as unwell and had required hospitalisation following a period of sickness in late January. A support plan had been devised by the acute hospital regarding supporting the resident if unwell and ensuring that their nutrition was maintained. The provider had developed their own plan mimicking this information. An inspector found that the plan created by the provider differed from the one developed by the acute hospital, this had the

potential to lead to confusion and errors as both plans were stored in the residents file. For example a staff member gave incorrect information on when medical supports should be sought for the resident if unwell and also regarding the residents nutritional intake.

One of the inspectors spoke with two staff members regarding the plan. One staff member gave a clear and accurate appraisal of the plan. The second staff member gave the inspector information that did not match either plan. Therefore, improvements were required to ensure that staff members were fully aware of how to support the resident.

Judgment: Not compliant

Regulation 7: Positive behavioural support

As discussed earlier, it was found that behaviours of concern had increased in recent months for one resident. An inspector sought to review information where the provider had investigated the increase in the behaviours. The available information did not demonstrate that the provider had made every effort to identify and alleviate the cause of the behaviours. Episodes of challenging behaviour were to be recorded by staff supporting the resident to ensure that the resident's behaviours could be appropriately tracked and addressed. However, the deputy manager could not locate the recording sheets for February, which impacted the response to the resident's needs.

The residents' key workers had developed a crisis support plan. The plan listed the resident's behaviours and gave some information on how to respond to them. However, enhancements were required, with more information needed to help staff better understand why the residents presented with the behaviours and how best to support them.

Restrictive practices were utilised in the residents' homes on a daily basis. Reviewing the restrictive practice log showed that bed rails were used daily. However, a member of the MDT team supporting the residents stated that they would not be prescribing the use of bed rails. The bed rails continued to be used despite this. As per the regulations, the person in charge is responsible for ensuring that all alternative measures were considered before utilising a restrictive practice and ensuring that the least restrictive procedure for the shortest duration was used. There was no evidence to show that the person in charge or the provider had assessed why the bedrails were required. This did not reflect best practice.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider and staff team supporting the residents ensured that the rights of each resident were being upheld and promoted. There was evidence of staff members acting on behalf of residents and seeking the best possible outcomes for the residents.
As discussed in earlier parts of the report, the staff team were observed to respond to residents in a caring and respectful manner. Staff members also supported residents in identifying and engaging in activities they enjoyed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Woodbrook Lodge OSV-0008012

Inspection ID: MON-0039297

Date of inspection: 11/04/2023

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: Any of the outstanding training has been scheduled. 3 of the current team do not have TCI and this is due to take place in the month of May, another staff member is currently on maternity leave and will receive this training upon her return. With regards to Epilepsy the person identified as not having the training is trained, therefore the entire team are Epilepsy trained. The one staff member who does not have SAM's training has now been scheduled to do this on the 14th of May. 3 staff require Peg training but one of them is on maternity so will be trained upon her return. The other two staff are new to the centre and it will take a number of weeks to adequately train them in the use of the peg. They will receive their initial training on the 10th of May, then shadow experienced staff until they are assessed as competent themselves. No staff member untrained in Peg feeding will use the Peg. Going forward the Training Record will clearly identify a date for any outstanding training and this will be done in a more timely manner to illustrate that management are aware of it and that the deficit has been addressed.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: As there were issues with oversight of IPC practices, Positive Behavioural Support, and Restrictive Practice, measures will be put in place to ensure better governance. IPC will	

be added to the Managers Weekly Checklist, Restrictive Practices and Positive Behaviour Management will be added to the Team Meeting agenda. This will ensure there oversight and review on a regular basis.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: The medication fridge is to be replaced as is the thermometer used to assess the temperature of the fridge on a daily basis. The fridge is also now stored on a tabletop. Management will also highlight to the staff team during a team meeting the importance of ensuring consistency with daily checks on the temperature of the fridge. They will also be advised to flag any readings above 8 degrees to management. The fridge checks will also be added to the weekly management checklist to ensure adequate oversight. This will include the main kitchen fridge to ensure appropriate storage of food. With regards to appropriate cleaning of the vehicles, these will also be added to the weekly managers checklist to ensure spot checks to identify any issues with cleanliness. The van which has an issue with the interior roof will also be returned to the mechanic to determine what can be done to improve it. All the issues above will also be discussed at a team meeting under Health and Safety / IPC to remind staff of the standards expected in terms of cleaning and IPC measures.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The method of which residents are to be evacuated from the first floor, should they be trapped up there with staff during a fire, are now clearly stated in each residents individual PEEP. This issue will also be discussed at a team meeting to ensure all staff are aware of this process.

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: There is now only one unwell plan/feeding regime on file for the resident in question, as the other was removed. This will prevent any confusion with regards what action to take should they become unwell, whilst creating clarity on what the resident's feeding protocol is. This will again be reviewed at a team meeting to ensure that all staff are familiar with the document in question and have a full understanding of it.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The crisis support plan will be reviewed and updated to ensure that it provides enough information offering explanations as to why the resident in question presents with the behaviours of concern. It will also include clear options of how to best respond should the resident become frustrated and present with such behaviours of concern. A review of the behaviours will also take place at a team meeting. In relation to the use of bedrails, the Person In Charge will continue to liaise with the OT to determine if they will sign off on the use of bedrails. In the meantime, a Risk Assessment is to be done for each resident highlighting the risks of not using the bedrails and what measures are in place to reduce the risk of actually implementing use of the bedrails.

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 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	02/06/2023
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	02/06/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare	Not Compliant	Orange	02/06/2023

	associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	02/06/2023
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	02/06/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or	Substantially Compliant	Yellow	02/06/2023

	environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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.	Not Compliant	Orange	02/06/2023