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:	An Grainan
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	28 February 2022
Centre ID:	OSV-0008100
Fieldwork ID:	MON-0035289

About the designated centre

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

In An Grainan, residential care and support is provided on a 24 hour basis for up to 18 residents over the age of 18 with an intellectual disability. The centre consists of three purpose built bungalows on a campus in an outer suburb of Dublin. Each house has six single bedrooms and suitable private and communal space to meet the needs of up to six residents. Residents are supported by a person in charge, clinical nurse managers, care staff and household staff. There are good public transport links and local access to restaurants, shops, cinema, churches and libraries.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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
Monday 28 February 2022	09:30hrs to 17:00hrs	Marie Byrne	Lead
Monday 28 February 2022	09:30hrs to 17:00hrs	Sarah Carter	Support

What residents told us and what inspectors observed

Overall the findings of this unannounced inspection were that residents appeared happy, comfortable and content in their homes; however, improvements were required in relation to the oversight and the day-to-day monitoring of care and support in the centre. This was required to ensure that residents were in receipt of a good quality and safe service.

As the inspection was completed during the COVID-19 pandemic, the inspectors adhered to national best practice and guidance with respect to infection prevention and control, throughout the inspection. The time spent with residents and staff, was limited and done in line with public health advice. Inspectors had the opportunity to visit each of the three houses in the designated centre and to meet and briefly engage with seventeen of the eighteen residents living there.

Following a number of inspections where there were poor levels of compliance with the regulations, and limited oversight and monitoring of care and support for residents, the provider made a decision to submit an application to vary to divide a designated centre into two which resulted in an application to register this designated centre. There were six houses in the larger designated centre, there were now three houses in this designated centre.

Throughout the inspection residents were observed to receive staff support in a kind and caring manner. Staff were observed to speak with residents while supporting them, and to respond to residents' requests in an appropriate and timely manner. Staff were observed to be familiar with residents' communication needs and preferences and those who spoke with the inspectors were motivated to ensure that residents were happy and safe in their homes.

Some residents were observed being supported by staff to engage in home-based activities during the inspection. They appeared happy engaging in these activities and very comfortable in the presence of the staff supporting them. Examples of these activities included, having their hair curled, completing table top activities, knitting and playing cards.

Staff told inspectors that residents enjoyed arts and crafts and watching their favourite television programmes. One resident was out for a walk on the campus with a staff member when inspectors visited their home. While residents appeared comfortable and content in their homes, there was limited evidence of residents engaging in activities outside of their homes, or off the campus.

One resident showed an inspector around their bedroom. They said they enjoyed spending their time there. They had a television and talked about their favourite programmes. They also showed the inspector their favourite possessions and family photos. Another resident spoke with one of the inspectors about their upcoming birthday and how much they were looking forward to it as they were planning to

have their birthday celebrations in a hotel.

Each of the three houses were clean, warm and homely. Each resident had their own bedroom which was decorated in line with their wishes and preferences. They had access to plenty of private and communal spaces in their home. Each area of their homes were accessible to them and they had access to pleasant and well maintained outdoor spaces.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

Overall the findings of this inspection were that residents appeared happy and comfortable living in the designated centre; however, inspectors found that improvements were required in relation to the monitoring and oversight of care and support for residents. For some areas reviewed, there was an absence of systems to guide staff practice, and some of the management systems in place were not proving fully effective.

While some improvements were noted since the designated centre with six houses had been divided into three houses per centre, areas where improvements were required were similar to previous findings in the larger centre. Due to concerns relating to the oversight and monitoring of care and support and the heightened risk for residents associated with this, a meeting was scheduled with the provider after the inspection.

The person in charge identified for this centre had returned to their original post on night duty the week before the inspection. They had initially been redeployed to the centre as person in charge for a period of three months in 2021, but this had then been extended to six months. As they were now back in their original night duty post, they were no longer in a position to ensure the day-to-day oversight of the centre, or available to support residents and staff in the centre.

Overall inspectors found that there there was limited evidence of oversight and monitoring in the centre. There was a small number of audits being completed locally, but there was limited evidence of follow up and completion of actions from these. The provider was completing six monthly reviews of care and support in the centre; however, these reviews did not pick up on some of the areas for improvement found during this inspection. There were limited actions identified from the latest review, and some actions marked as complete, were not found to be complete at the time of the inspection. The provider had completed an annual review for 2020, and inspectors were informed that the annual review for 2021 was in the process of being completed at the time of the inspection.

Inspectors found that staff and members of the management team were very familiar with residents' care and support needs, and picking up on any changes in relation to their healthcare needs, and responding appropriately. However, despite the local management team being able to tell the inspectors where improvements were required during the inspection, inspectors were not presented with evidence to show that they had capacity to bring about the required improvements. This was partially due to a lack of resources in terms of staffing and managers.

There were a number of staff vacancies at the time of the inspection, and there were a number of staff on planned and unplanned leave. It was evident that the provider was attempting to ensure continuity of care and support for residents while recruiting to fill vacant positions. However, this was not always proving possible. A sample of staff files was reviewed by an inspector on the day of the inspection and a number of them, were missing some information required by the regulations.

Inspectors found that there were some systems to support the staff team to carry out their roles and responsibilities such as an on call manager; however, formal staff supervision was not occurring in line with the organisation's policy. Inspectors were provided with a schedule for staff supervision for 2022, after the inspection. However, this did not demonstrate that each staff would have formal supervision in line with the organisation's policy. Staff had access to training and refresher training; however, a small number of staff required training or refresher training in food safety and fire training. Inspectors were shown evidence of availability of these courses for staff.

Regulation 14: Persons in charge

The provider had redeployed a clinical nurse manager initially for a period of three months to the person in charge role in this centre. This had then extended to six months. However, the clinical nurse manager returned to their original post on night duty the week before the inspection. As a result, due to competing demands they were not available to ensure effective day-to-day oversight or monitoring of care and support in the designated centre. Inspectors were informed that the provider was actively recruiting to fill the person in charge post, and that interviews had been held prior to the inspection.

Judgment: Not compliant

Regulation 15: Staffing

There were a number of staff vacancies at the time of the inspection, including the person in charge post. In addition, there were a number of staff on planned and unplanned leave. It was evident that the provider was attempting to ensure

continuity of care and support for residents while recruiting to fill vacant positions. However, they remained under resourced, particularly in relation to managers.

There were planned and actual rosters in place and regular relief and agency staff were covering the required shifts.

A sample of staff files was reviewed by an inspector on the day of the inspection and some did not contain all of the information required by the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

Formal staff supervision was not occurring in line with the organisation's policy. Inspectors were provided with a schedule for staff supervision for 2022, but this did not demonstrate that it would be completed in line with the organisation's policy.

Staff had access to training and refresher training. A small number of staff required refresher training in areas such as, fire safety, and food hygiene.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall inspectors found that improvement was required to ensure ensure that the service provided for residents was consistently and effectively monitored. While there were some management systems in place, they were not being fully implemented or proving fully effective. There was limited evidence of audit, and where they were occurring they weren't always followed up on, or leading to improvements.

The provider was completing an annual and six monthly reviews in line with the requirements of the regulations. However, these audits and reviews were not capturing all of the required areas for improvement, and where some actions were marked complete, they were not found to be complete during the inspection.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

A sample of residents' contracts of care were reviewed and found to contain the

required information, including the supports and services to be provided for residents, and the fees to be charged.

Judgment: Compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents occurring in the centre and the Chief Inspector was notified of the majority of these. However, the Chief Inspector was not notified of a non serious injury for a resident in line with the timeframe identified in the regulations. In addition, a number of restrictive practices were not reported in line with the requirement of the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were complaints policies and procedures in place. However, the policy in the folder for the centre was not the provider's most up to date policy. There was a small number of complaints recorded and evidence that they had been followed up on in line with the organisation's policy. However, there templates in use that were not consistent with the provider's policy and improvements were required as there was an absence of a clearly defined system for the oversight of complaints. Complaints were not consistently discussed at staff and management meetings. Complaints was found to be a standing agenda items at residents' meetings.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that residents were well cared for and lived in pleasant, well maintained homes. They were supported to stay well, and to stay safe. However, there was limited evidence to demonstrate that residents were supported to balance risks while having opportunities to take part in activities outside of their homes, or off the campus. Improvements were also required in relation to recognising and reporting restrictive practices, and in relation to the oversight of residents' finances, risk management, and the storage of large items.

Inspectors found that some improvement had been made in relation to residents' access to and control of their finances. Attempts were ongoing to support residents

to open accounts in their name in financial institutions. In line with the findings of the previous inspection in the larger designated centre, there were some systems to safeguard residents' finances. However, these were not proving fully effective in ensuring oversight of residents' finances. There were systems to log residents' income and spending and staff in the houses were double signing these records and regularly checking residents' wallets to ensure the balances matched. However, inspectors reviewed a number of records where small amount of residents' money were spent on items that should have been purchased from the centre's petty cash fund. Inspectors were given assurances that residents' would be reimbursed for these monies spent.

Inspectors reviewed a sample of residents' activity records and found that residents were spending the majority of their time in their homes or on the campus. While there was evidence that residents were engaging in activities in their home which they found meaningful, there was limited evidence to demonstrate that some residents had left their home or the campus during the four week period reviewed.

Each of the houses was tastefully decorated and homely. Overall the design and layout of the premises was ensuring that residents lived in an accessible, safe and comfortable home. Residents could access and use the spaces available to them both in their homes and in their gardens. Residents bedrooms were spacious and contained adequate storage for their personal possessions. However, there was insufficient space in the houses to store larger items. The provider was aware of this and was in the planning stage of getting secure outdoor storage for these larger items.

Inspectors found that some improvements were required in relation to risk management in the centre. There were multiple systems in place, and duplication of documents. The systems in place were not reflective of the provider's current policy, and the risk register was in development at the time of the inspection. There were systems to record incidents and evidence of trending of this information and that this information was being used to inform the development of the new risk register.

The provider had infection prevention and control policies in place and they had adapted their policies and procedures and developed contingency plans for use during the COVID-19 pandemic. Staff had completed a number of infection prevention and control related trainings. Residents and staff had access to information in relation to standard precautions and COVID-19. There were cleaning schedules in place and each of the houses were found to be very clean during this unannounced inspection. There were stocks of personal protective equipment (PPE) and systems in place for stock control.

There were suitable arrangements for detecting and extinguishing fires, and systems to ensure fire equipment was regularly serviced, tested and maintained. Fire evacuation procedures were on display, and fire drills were occurring regularly. Resident had a personal evacuation plan which detailed any supports they may require to safely evacuate the centre in the event of an emergency.

There was a small number of restrictive practices in the houses. However, these had

not been recognised or reported as such. These restrictions were not reported by staff to be used in the management of behaviours of concern, but were reported to support residents with medical conditions, or to be for health and safety reasons. They needed to be reviewed to ensure they were the least restrictive for the shortest duration, and if deemed appropriate, they needed to be recorded as restrictions and regularly reviewed.

Regulation 12: Personal possessions

Inspectors found that there were some systems in place to protect residents' from financial abuse; however, improvements were required to ensure residents' finances were not used to buy items that were the responsibility of the provider to purchase. In addition, practices in relation to spending residents' money was not found to be person-centred. While the items purchased were items residents wanted or needed, they were not going out to purchase these items. While this practice may have been appropriate at times when there were restrictions relating to COVID-19, these restriction were now lifted.

Judgment: Not compliant

Regulation 13: General welfare and development

From a review of residents' financial and activity records, it was evident that residents were spending the majority of their time in their home, or on the campus. While they had opportunities to engage in activities they found meaningful in their home, there was limited evidence of the development of goals or opportunities to participate in activities in their local community.

Judgment: Not compliant

Regulation 17: Premises

Residents lived in warm, clean, comfortable, and spacious homes. They had access to adequate private and communal spaces and pleasant outdoor spaces, and residents' bedrooms were personalised to suit their tastes. They had access to plenty of storage for their personal items; however, there was a lack of storage space for large items such as residents' wheelchairs and comfy chairs. The provider was aware of this and plans were in place to source suitable outdoor storage for these.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Inspectors found that the organisation's risk management policy did not provide guidance on the multiple systems in place in the centre. There was duplication of documentation and limited evidence of oversight of risk in the centre. The centre's risk register was in development and required further work at the time of this inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had developed infection prevention and control policies and procedures, and they had developed contingency plans for use during the COVID-19 pandemic. There was information available and on display for residents and staff in relation to standard precautions and COVID-19. There were good stocks of PPE and systems for stock control. Staff had completed a number of infection prevention and control related trainings. Each of the houses were found to be clean during the inspection and there was documentary evidence to show that each area of the three houses were regular cleaned.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements for detecting, containing and extinguishing fires. There were adequate means of escape and emergency lighting in place in key areas. There were systems to ensure fire equipment was regularly serviced, tested and maintained.

The evacuation plan was on display and residents' had personal emergency evacuation plans in place. Fire drills were occurring regularly and demonstrated that they had been completed at times when there were the least number of staff and the highest number of residents present.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was a small number of restrictive practices in the houses. However, these had not been recognised or reported as such. Staff reported they were not used for the management of behaviours of concern but rather to support residents with medical conditions, or for health and safety reasons. They needed to be assessed to ensure they were the least restrictive for the shortest duration and then recorded and regularly reviewed.

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	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for An Grainan OSV-0008100

Inspection ID: MON-0035289

Date of inspection: 28/02/2022

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Person in Charge commenced 28.03.2022. The Person in charge will provide governance and oversight to the designated Centre.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Person in Charge commenced 28.03.2022 Staff recruitment for current vacancies is on going. RIND Graduate recruitment Day held on 2nd March 2022. Engagement with recruitment agencies continues to source all grades of staff.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Formal Supervision Schedule has been reviewed for 2022 and will be in line with the organisational Policy.	

Training Needs Analysis has been updated and identified outstanding staff training required. Training will be scheduled in areas as identified and will include Food Safety and Fire Training.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PIC has been appointed since 28.03.2022

Audit schedule has been devised for the Centre. PIC will review and action any findings from the audit. All findings will be shared with residents and staff meetings.

Six monthly review will be redone and will identify and reflect all areas for improvement. All findings will be actioned and completed in accordance with allocated times frames.

Annual review for 2021 will be completed actioned and available for inspection

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All notification of incidents will be reproted within the timeframe as per Regualations.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Latest version of Complaints Policy has been placed in complaints folder.

The PIC will implement a three monthly audit of all complaints within the Centre to ensure evidence of oversight in the Centre. PPIM will review complaints on a monthly

basis with PIC.

Complaints will be a standing agenda on residents and staff meetings.

Complaints Policy is currently being reviewed to reflect clear and defined systems for the oversight of complaints and will include all documentation in the Service.

The PIC will conduct a three monthly audit for all complaints in the Centre.

The PPIM will review all complaints monthly with the PICs.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Residents are currently being supported in their application to open account in financial institutions.

A review of all individual financial logs has taken place and monies has been credited form the Service to the individuals effected. Whereby money was spent on items that should have been purchased by the Centre.

The PIC and PPIM will review all individual financial expenditure monthly to ensure compliance and that individuals are involved in personal purchases.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Residents in the Centre will be supported to engage in Community based activities.

Weekly consultation with residents will assist with planning of activities outside the home. New weekly planner has commenced and daily evaluation of same activities.

Monthly keyworker meetings will be held with each resident to explore meaningful activities in the community and evidence will be documented in Quality of Life section in individual Care Plan.

PPIM and PIC will evaluate individual community participation monthly and implementation action plans accordingly.

Social goals for all residents is currently being reviewed and will reflect individual will and preference re social engagement in their Care Plan or PCP.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Sourcing of outdoor storage facilities are currently in progress. Ground works have been sent to tender and expected by 22nd April 2022. Works to be completed by 31st May. Storage sheds are currently being sourced and awaiting confirmation re availability.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk Management Policy is currently under review and will provide guidance to staff on the management of risk.

Fire Policy including all associated documentation is under service review.

Risk Management training working was provided by quality and Risk Office to the CNM 1 on 8th March 2022.

Risk Management workshops scheduled for the Centre.

All Risk Assessments in the Centre are currently being reviewed. All Risk Assessments will be placed in relevant section in Individual Care Plan.

Risk register will reflect all risks in the Centre and available for review.

Risk Management will be incorporate into local safety pause and staff meetings.

PPIM will meet with PIC monthly and review Risk Management in the Centre.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All restrictive practices in the Centre have been reviewed. Restrictive practice will be used for shortest duration and recorded and reviewed three monthly.

All restrictive practices will be reported in time with Regulation.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	25/03/2022
Regulation 12(4)(b)	The registered provider shall ensure that he or she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the account is in the name of the resident to which the money belongs.	Substantially Compliant	Yellow	25/03/2022
Regulation 13(2)(a)	The registered provider shall	Not Compliant	Orange	31/08/2022

	provide the following for residents; access to facilities for occupation and recreation.			
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/08/2022
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/08/2022
Regulation 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	28/03/2022
Regulation 15(1)	The registered provider shall	Substantially Compliant	Yellow	31/10/2022

	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.			
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	31/10/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/10/2022
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	20/05/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Substantially Compliant	Yellow	30/09/2022

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2022
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	31/07/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2022
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	01/09/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the	Substantially Compliant	Yellow	30/07/2022

	lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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.	Not Compliant	Orange	30/07/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	30/07/2022
Regulation 26(1)(a)	The registered provider shall ensure that the	Substantially Compliant	Yellow	01/09/2022

	risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	01/09/2022
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	01/09/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in	Not Compliant	Orange	01/06/2022

	place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	30/03/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	30/04/2022
Regulation 34(1)(d)	The registered provider shall provide an	Substantially Compliant	Yellow	01/07/2022

	effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Substantially Compliant	Yellow	01/07/2022
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	01/07/2022
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative	Not Compliant	Orange	30/06/2022

	measures are considered before a restrictive procedure is used.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/06/2022