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:	Clochan House Residential Respite Centre
Name of provider:	Offaly Centre for Independent Living CLG
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	06 September 2021
Centre ID:	OSV-0001930
Fieldwork ID:	MON-0032966

About the designated centre

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

Clochan House is based in a large town in Co. Offaly. It is within walking distance of the town centre, but transport is also available for residents. The service provides respite for up to five adults both male and female, aged between 18 and 65 at any one time, with new referrals accepted up to the age of 65. Residents in this centre are referred to as 'leaders' in this centre and are supported by personal assistants during their stay. It operates from Monday to Friday. It is closed at the weekend. The centre is attached to a health care facility which provides cooked meals. Within the premises there are five bedrooms, a sitting room, a visitors room, an activity room and a kitchen, as well as offices and staff facilities. One bedroom is en-suite while the other bedrooms have access to shared bathrooms. Two bedrooms have a ceiling track hoist. . The respite centre is based on the needs and desires, goal and choices of service users. The ethos of the centre is to support residents' independent living in accordance with residents' independent needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 6 September 2021	10:00hrs to 18:00hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

Two individuals were in the process of being admitted to the respite service on the day of inspection. The inspector had the opportunity to speak with the service users and the staff supporting them and review documentation which recorded some aspects of the care and support provided. Residents presented with physical disabilities and communicated their thoughts verbally. The respite service had been closed for an extended period of time prior to the inspection day due to COVID-19 and the centre had just resumed offering the respite service to the service users two weeks prior to the inspection day.

COVID-19 measures were adhered to on the day of inspection with staff and the inspector wearing face masks and maintaining a two metre distance in line with national COVID-19 guidance for residential care facilities.

The centre was attached to the local general hospital and the premises had previously been a ward in the hospital. There were five bedrooms, a sitting room, a visitors room, an activity room and a kitchen in the premises, as well as offices and staff facilities. One bedroom was en-suite while the other bedrooms have access to shared bathrooms. Some works were being completed to the outside of the premises on the day of inspection. This was to ensure that the garden area at the front of the premises was fully wheelchair accessible.

There was clear admission criteria in place should an individual wish to avail of the respite services in Clochan House. The person in charge completed comprehensive assessments of need before determining if the respite service could meet the needs of the individual. The person in charge also determined what groups of residents availed of respite together, by looking at their support needs and and potential risks. The provider and person in charge ensured that when a service user was admitted to the respite service, adequate resources were in place to meet their needs, including appropriate assistive equipment, appropriate staffing levels and medications.

The inspector had the opportunity to meet with the two respite users on the day of inspection. Staff referred to respite users as "leaders" and indicated that this was secondary to the respite users leading the service that was provided. The inspector noted pictures of staff supporting the service users displayed in the hallway of the centre. Two bedrooms had been prepared for the service users attending respite that night. The inspector observed the rooms were clean and there were folders available to the residents in the bedrooms with information regarding the complaints procedure and advocacy services. Respite users were also provided with a feedback form where they could share their views about the service and their respite stay with the provider.

Meals were provided from the hospital attached to the premises and service users were provided with menus and choices for meal options. The centre had a kitchen

with facilitates to cook and prepare meals if needed. One resident communicated that the meals were very nice when asked by the inspector. The inspector observed the respite user enjoying a cup of tea with a staff member at the kitchen table in the afternoon. Positive interactions were observed between staff and respite users during the inspection day.

In general, the inspector found that service users were well supported during their respite stays. There was a regular management presence in the centre and staff support was appropriate to meet the needs of the respite groups. The inspector looked at a number of areas which impacted the care and support provided to residents including staffing, management, complaints procedures, fire safety, risk management, admissions, infection control, personal plans and medication management. While some areas of non compliance were identified, the inspector found that management and staff were striving to provide safe support to service users during their respite stay and that service users were enjoying and benefiting from their stay in Clochan House. Some improvements were required to ensure the centre was always operating safely and with higher levels of compliance with the regulations as discussed in the below sections of the report.

Capacity and capability

This was an unannounced inspection which was used to determine the centres levels of compliance with the regulations. Some areas for improvement were identified on inspection in areas including fire safety, medication management and personal plans. This did not appear to impact service users having a positive experience during their respite stays. The inspector found that the centre was appropriately resourced to meet the needs of the individuals availing of respite.

There was a clear management structure in place and a regular management presence in the designated centre with a full time person in charge and team leader. Schedules were in place to regularly check, audit and review the service provided. However, the service had been closed since March 2020 and therefore a six monthly and annual review of the care and support had not been completed in recent months. Some issues highlighted during the inspection had not been self identified by the provider to ensure that the service provided was always safe this included areas of non compliance or substantial-compliance in fire safety, medication management, notification of incidents and personal planning.

There was a clear and comprehensive pre-admission and admission process in place prior to service users availing of respite in the centre. Respite was determined on the basis of clear criteria. Compatibility of respite groups was a focus prior to admissions and service users attending the respite service and their families regularly communicated with the provider regarding their views of the service. Respite users and their families often communicated that they regarded the respite stays in the centre as a holiday house.

Regulation 14: Persons in charge

There was a full time person in charge in place who had the skills and experience necessary to effectively manage the designated centre and who met the requirements set out in regulation 14. This person had a regular presence in the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The staff team comprised of the person in charge, who was a registered nurse, a team leader and personal assistants. Staffing levels were in place to meet the assessed needs of the respite service users. Staffing levels were determined by the mix of service users availing of respite and their support needs. The provider had recruited a mostly new staff team due to the service being closed since March 2020. There was a staff rota in place that was maintained to clearly detail staff shifts and support levels in place.

Judgment: Compliant

Regulation 16: Training and staff development

Training was provided in areas including manual handling, first aid, fire safety, safeguarding, infection control and behavioural management. Training needs were regularly reviewed by the person in charge and additional training scheduled when necessary. There was a policy and schedule in place to provided one to one formal supervisions with staff members on a regular basis. The service had been closed prior to the inspection since March 2020 and therefore the majority of the staff team had recently been newly recruited. New staff had undergone a induction period and had completed training in a number of areas.

Judgment: Compliant

Regulation 23: Governance and management

There were clear management systems in place and a full time person in charge

who had a regular presence in the designated centre. There was also a full time team leader in place who was part of the staff compliment. The management team were responsive to the inspection process and appeared knowledgeable regarding the respite users needs and the service provided.

The centre had been closed for almost a year and a half and had just resumed offering respite services to service users two weeks prior to the inspection day. This was secondary to COVID-19. Therefore an annual review of the quality and safety of the care and support provided had not been completed for the year 2020. Likewise six monthly unannounced inspections had not taken place. Some issues highlighted during the inspection had not been self identified by the provider to ensure that the service provided was always safe. This included issues identified in fire safety, medication management and personal planning.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider and person in charge had ensured that there were clear admission processes and criteria in place for respite users in Clochan House. Respite users had contracts of care in place which were signed by service users and detailed the fees to be paid for the nights of their stays in respite.

A pre-arrival form was completed prior to the service users respite stays and these reviewed their personal information, contact details and needs. Pre-admission forms were sent out to respite users one month before their stay. There was also a checklist sent out to respite users prior to attending respite and this included checks regarding residents belongings, assistive equipment required, any appointments scheduled during their stay, finances and communication tools needed. The service had also recently introduced a COVID-19 questionnaire which was completed by service users prior to their respite stay.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector noted some restrictive practices in the centre that had not been notified to the chief inspector at the end of each quarter of each calendar year as required by regulation 31.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure was readily available to service users and families were made aware of this. Comments and complaints regarding the service provided were treated seriously by the provider and person in charge. Residents and their families were regularly consulted regarding the service provided. There was a designated complaints officer who was responsible for the management of complaints when they arose.

Judgment: Compliant

Quality and safety

Overall, inspection findings suggested that the registered provider was striving to provide a person-centred and effective service to respite users. Systems were in place to ensure risk management measures were in place and that service users were safeguarded. Some improvements were required to ensure that the service provided was safe at all times, this was namely in the areas of medication management and fire safety. Issues were noted with fire containment measures on the day of inspection. Improvements were also required to ensure that medications were always administered safely and in line up-to-date guidance and with medication management training as detailed under regulation 29.

There were systems in place for safeguarding residents. Residents were observed to appear comfortable and content in their home. All staff had up-to-date training in safeguarding vulnerable persons and there was a clear escalation process in place on what to do in the event of a concern or allegation.

The provider had ensured that systems were in place for risk management in the centre including management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required. There was infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment (PPE), including hand sanitisers and masks, were available and were observed in use in the centre on the day of the inspection.

Regulation 26: Risk management procedures

There were clear systems in place in the centre for risk management. The provider had a risk audit committee in place who regularly reviewed risk management

systems in the service. There was a centre risk register which considered all actual and potential risks including the impact of the COVID-19 pandemic, adverse weather conditions, falls risks and fire risks.

There was a service emergency contingency and evacuation plan in place and service users had individual risk assessments in place including the assessment of risks associated with falls, epilepsy, allergies, diabetes, mental health and swallowing risks. These were subject to review when service users were availing of respite.

Judgment: Compliant

Regulation 27: Protection against infection

Measures were in place for infection prevention and control in the designated centre. All staff had completed training in infection prevention and control. Signage was observed around the respite service with information regarding COVID-19, hand hygiene and infection control measures. There was an information folder in place for staff to access up-to-date information regarding the management of COVID-19 in residential care facilities. The centre had appropriate access to PPE when required. Staff and residents were completing regular temperature checks on arrival to the centre and recording them.

Cleaning schedules were in place to ensure that all aspects of the centre was regularly cleaned. Cleaning schedules also considered noise levels in the centre at night to promote a peaceful nights sleep for residents. Staff had specific allocated tasks during every shift. Checks were in place to reduce the risk of water borne infections in water systems and the inspector observed staff completing these checks on the day of inspection.

An service action plan had been developed for in the event that a resident or staff member presented as positive for COVID-19. Easy Read Guidance for COVID-19 swabbing and testing had been developed for residents. A room had been identified for isolation purposes in the centre and there was a service COVID-19 risk assessment in place.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector observed fire safety systems in place around the designated centre. This included detection systems, fire fighting equipment, signage and emergency lighting. There were clear exit routes in place around the centre. Regular fire safety

checks and tests were completed by staff in the centre.

Some issues were noted with containment systems in the centre following a walk around. One fire door was fully closing and one door extender in the centres kitchen was observed as open on the day of inspection with no closing mechanism in place. This meant that these containment measures would not be fully effective in the event of a fire in these areas. The person in charge immediately notified the service health and safety manager during the inspection when this was identified.

Personal emergency evacuation plans were in place for service users and these were reviewed prior to residents respite admissions. These outlined day and night time evacuation procedures. Plans were in place to complete regular fire evacuation drills from the centre, however records of drills were not available for review on the day of inspection as the centre had been closed since March 2020.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication management systems in the centre required review to ensure that systems were always safe. In general, staff were not administering medicines in line with the ten rights of medication and therefore were also not administering medicines in line with the safe administration of medications (SAMs) training that they had received or in line with up-to-date guidance. Residents did not have prescription kardex's in place. Resident's prescriptions from their general practitioner (GP) did not always stipulate administration times, medication routes or medication forms such as liquid, tablet or powders. The administration of each drug for each resident had not been appropriately recorded and signed off by staff. There was a system in place for assessing if residents were independent with administering medication. However, some residents had been deemed as independent when staff were physically fully supporting them with the administration of medicines while in receipt of respite support.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

All residents had a running file in place with assessments of need and personal plans in place. As the centre had recently been closed for an extended period of time, these were in the process of being updated as residents began to attend respite again to reflect residents most current needs. Staff maintained daily notes during service users respite stays and these detailed daily routines and activities completed

by respite users.

Service users assessments of need were reviewed prior to every respite admission. Plans included supports levels required during activities of daily living including personal care, elimination, feeding and communication. Further plans were developed when respite users had specific healthcare needs. However at times, personal plans in place were generic and lacked individual details about respite users, for example the specific levels of support required in areas including assistance required for supporting residents to mobilise.

Judgment: Substantially compliant

Regulation 8: Protection

Service users appeared to be safeguarded during their respite stays. Compatibility of residents was considered prior to every respite stay and residents feedback regarding the service provided was reviewed and considered by the person in charge and the provider. All staff had received up-to-date training in the safeguarding and protection of vulnerable adults.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Clochan House Residential Respite Centre OSV-0001930

Inspection ID: MON-0032966

Date of inspection: 06/09/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. An annual review of the quality and safety of the care and support provided by management and staff in the center was not completed while the service ceased secondary to Covid-19. Now that the service has now reopened, an annual review will be completed for the period from 23rd August 2021 and 23rd August 2022. 2. Registered Provider Representative/Chairperson of Board of Directors, will carry out a 6 monthly unannounced inspection as outlined in Regulation 23. The Centre will be six months reopened on 23rd of February 2022 and an inspection will take place on or before this date. 3. Weekly Management meetings will continue to take place on a Tuesdays from 2pm-4pm (minutes recorded) and includes all aspects of the operations of Clochan House. Members of this Management meeting includes General Manager, HR consultant, Finance Manager, Covid coordinator, Manager of Community Service.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: 1. Restrictive practice on the day of inspection included 4 doors within the Centre that were on a swipe card access. Leaders did not have swipe cards to allow them to access these areas. Swipe cards were obtained within the week of the inspection and were made available for Leader use in order to be compliant with Regulation 31. The doors include:	

Staff Sleepover room for staff member on-call
Staff canteen and handover room
PIC office
Covid-19 Isolation room

2. Following consultation with the residents, staff and with OCIL Management, a collective opinion was formed that the staff's right to privacy while they sleep outweigh's the Leader's need to access this particular room... This room was removed from the Leader's swipe card based on considerations of the rights of both parties.
3. A decision for residents to have access to the PIC's office and the common staff room remains an option for Leaders.
4. Access to the Covid-19 isolation room is available also and Leader's will be made aware of the function of this room and the risk assessment required to access the room at any given time.
5. HIQA was notified of this restrictive practice on 30.09.21 as part of the quarterly NF39A. PIC will continue to notify HIQA using the HIQA Portal within the allocated time frame of all incidents as outlined in Regulation 31.
6. Covid19 antigen tests are carried out by all residents on the morning of the arrival, before they leave their homes, to protect the Centre from infection out-breaks for NF02 notifications.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A fire door was not fully functioning on the day of inspection. This door is located between the living room/ activity room. Freshly applied paint was preventing the door from closing fully and therefore the door was no longer a containment door.
The paint has since been removed in the specific area that had prevented the fire door from closing fully. This door is fully functioning for opening and closing to comply with fire safety regulation.
2. The kitchen half door which allows accessibility for larger wheelchairs to pass through was not closed on the day of inspection and therefore was not a fire containment door. Staff have received training on 20.09.21 specific to the importance of this door being kept closed. The half-door has a discreet reminder sign on both sides of the door, to remind staff to close the door immediately after the wheelchair has passed through as it forms part of the fire containment door.
During a fire drill carried out on 20.09.21, by Fire Safety Consultant, it was found that both doors were compliant with Regulation 28.
A full evacuation was timed at total evacuation = 1minute 33 seconds.

Weekly HSE General Fire Routine checks are carried out where all electric fire doors close automatically. Audit carried out by PIC confirmed 25.09.21/ 17.12.21/ 07.01.22- All fire doors checked and functioning without difficulty.

An unannounced Audit by Team Lead carried out 23.11.21 showed Kitchen fire half-door closed/locked in place.

3. All firefighting equipment has been fully serviced and certified by Masterfire on 22.09.21.
4. All PEEPs continue to be update for each resident for each visit
5. The Centre's GEEP is current and has been approved by Fire Safety Consultant 20.09.21

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. Full review of previous Medication Management Policy has been carried out and relevant changes made in line with legislation. The latest Medication Management Policy is version 2.0 and came into effect on 04.10.21. This includes a clear and in-dept assessment of the resident and a precise instruction to staff of the level of assistance required by the resident. This is an ongoing process which commences on the day of arrival of the resident and on every visit to the Centre thereafter to capture a decline in the resident's ability to self-medicate or in their need for assistance.
2. Training completed with staff regarding assisting residents was carried out by Medicore on 04.10.21.
3. Medication Administration Recording Sheet have been designed specific to the designated Center and were rolled out on 20.09.21 directly to the relevant GPs.
4. Letters sent to residents in advance of their stay requesting a new Prescription and MARS to be completed by their GP was also rolled out on 20.09.21. This is an ongoing process which occurs prior to every visit of the resident to the Centre.
5. Letters sent to Pharmacies specific to each individual resident requesting a copy of a drug descriptor of each medication supplied within the resident's blister pack
6. A two-day SAMS training will take place for all staff working in the Centre on 7th/8th March 2022 by the Wolfe Group.
7. A booklet for each resident is now at the printers in Athlone to form a resident specific medication prescription and recording sheet for the Centre's residents.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual

assessment and personal plan:
1. All residents are involved with the self-referral process to avail of the service provided at the Centre. This includes completing a personalised plan template prior to their assessment visit to the Centre. They may be assisted to complete this form by their public health nurse, their community personal assistant, GP, social worker, a family member or friend. (This list is not exhaustive.)
2. During the initial assessment visit to the Centre or during the house visit by the PIC (Covid19 guidelines permitting) the resident speaks with the PIC and additional information is then added to the plan. The aim of this meeting is to gather more information from the resident regarding their preferences, needs, goals and dreams for their holiday stay. It also empowers the resident to introduce the PIC as to what their home life consists of, what support equipment they use at home and to show the PIC what items they wish to bring with them. (e.g. shower chair, sara steady etc)
3. In the event that a resident requires supports from the applied healthcare team, referral letters are sent for professional opinions to ensure a safe stay at the Centre prior to the date for the holiday being agreed (Speech and language, physiotherapy, wound care etc)
4. Again, on the week prior to the arrival date, the resident will complete a 'pre-arrival questionnaire' with the PIC over the phone, by email or zoom call, as an opportunity to obtain more information from the individual and to ensure that there has been no changes in their circumstances since the original assessment.
5. On the morning of arrival, the leader is contacted again as part of the Covid 19 health and safety plan, and this is an opportunity for staff and the resident to communicate any concerns, reassure them regarding times for arrival, transport, menu options for the day ahead etc. This list is not exhaustive.
6. This person-centered plan is reviewed prior to the resident departing the Centre on the Friday morning, to ensure that the person's needs and goals were met/achieved and the plan is reviewed again on every visit to the Centre thereafter, which is on average 3 times a year.
7. A resident 'satisfaction form' is completed on the Friday to give the person an opportunity to express their opinions, make a complaint or give feed back on elements of the service or staff for areas of improvement and quality of service provision.
8. During their stay, if there is a need for professional opinions for additional supports, the PIC will refer the resident for relevant allied healthcare professional review.

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 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	23/02/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	22/09/2021
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal	Not Compliant	Orange	18/02/2022

	and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
31 (3) (a)	Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	30/09/2021
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	