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:	Florence House
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	02 December 2024
Centre ID:	OSV-0002632
Fieldwork ID:	MON-0044719

About the designated centre

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

Florence House is a designated centre operated by the Health Service Executive (HSE). The designated centre provides a community residential service for up to eight adults with a disability. The centre is a detached two storey house set on its own grounds in a housing estate on the outskirts of a large town in County Wexford. It is located within a short distance of local facilities and amenities. The building consists of two floors, with the ground floor being accessible to residents and the upstairs floor used for office purposes. The centre's downstairs comprises of a sitting room, activity room, sensory room, dining room, kitchen, eight individual resident bedrooms, visitor room, laundry room, two shared bathrooms and two offices. There was a garden for residents to avail of if they wished. The staff team consists of a Clinical Nurse Manager (CNM) 1, staff nurses and multi-task workers. The staff team are supported by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 2 December 2024	09:30hrs to 17:30hrs	Conan O'Hara	Lead
Monday 2 December 2024	09:30hrs to 17:30hrs	Sarah Mockler	Support

What residents told us and what inspectors observed

The purpose of this inspection was to review actions taken by the provider to address the levels of poor compliance identified in the the previous inspection undertaken in July 2024.

Following the July 2024 inspection, due to the providers continued failure to meet the requirements of the Health Act 2007, the Chief Inspector of Social Services issued a warning letter to the provider. In response, the provider submitted formal written assurances to the Chief Inspector outlining their proposed actions to improve the standards of care and support in the centre.

Overall, the findings of the current inspection indicated that the provider had implemented a number of the actions as set out in their compliance plan and written assurances. However, there remained significant concerns in relation to the condition of the premises, oversight of restrictive practices and residents' rights.

This inspection was completed by two inspectors over one day. The inspectors spent time over the course of the inspection engaging with residents and staff, observing care practices, daily routines and the activities in the centre as well as reviewing documentation.

The inspectors had the opportunity to meet with four of the seven residents who lived in this house over the course of the inspection. The centre had capacity to accommodate eight residents but due to the needs of the residents the registered provider had transitioned one resident to another centre. All residents used different methods of communication, such as vocalisations, facial expressions, behaviours and gestures, to communicate their immediate needs.

On arrival, the inspectors observed one resident having breakfast in the dining room and one resident watching TV in the activation room. The other three residents were being supported to prepare for the day. The inspectors were informed that one resident was at home with their family, one resident was at a hospital appointment and one resident was self-isolating. Throughout the morning residents were supported to have breakfast and spend time in the sitting room and kitchen. Later in the morning, two residents were observed leaving the centre to go bowling while two other residents were supported to access their community. In the afternoon, following lunch the majority of residents remained in the centre either in the kitchen, sitting room or in their rooms with periods of time spent on personal care.

Overall, it was noted that there had been an improvement in residents access to activities and daily interactions with staff. However, this was in the very early stages of implementation and further focus on this area was required to ensure that the culture of promoting the residents' social care needs was embedded in daily practice.

The inspectors observed examples of 'task orientated' and 'institutionalised' care over the course of the day which negatively impacted on the lived experience of the residents. For example, the design and layout of the premises was also found to be clinical in nature and not conducive to a homely environment. The dining room was not decorated in a homely or inviting manner as it was a large room which contained only a heavy table and a set of chairs, one wall was painted black and the curtains were not hung in a proper manner and were hanging incorrectly from the curtain pole. Despite the provider providing written assurances to the Chief Inspector, this room had not been maintained to a suitable standard. The inspectors were informed that funding had been approved to renovate the dining room as well as other parts of the premises

In terms of institutional staff practices, inspectors found the centre still operated on a collective/mass management approach. Residents basic needs were being met but in a very institutional manner with little to no personalisation of care observed.

In addition, although new blinds had been installed throughout the centre, including on the window of the office door, the provider had failed to identify the need of privacy blinds on windows to the seven residents' bedrooms. Each residents' bedroom could be viewed from the communal hallway and there was no effective measures in place to ensure that residents' privacy and dignity was respected at all times.

In summary, the inspectors found that the centre was meeting the medical and personal care of residents. There had been improvements in meeting the social care needs and quality of life outcomes of residents. However, this was in the early stages of being implemented and continued work was required in this area. There remained concerns in relation to the design and layout of the premises, oversight of restrictive practices and residents' rights.

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

Capacity and capability

The current inspection found that some improvement in governance arrangements, general welfare and development and fire safety had occurred. However, the timeliness of the providers ability to bring about necessary changes and improvements in the centre remained a significant concern.

There was a defined governance and management system in place in the centre. A new person in charge had been appointed to the designated centre. The person in charge was in a full-time role and was suitably qualified and experienced for the role. In addition, the governance systems had been reviewed and the provider established a governance and oversight team to address areas for improvement.

The provider also introduced quarterly audits carried out by the Assistant Director of Nursing and an action monitoring log to implement actions identified from audits. Overall, the inspectors found that there was improved oversight arrangements in place which were in the early stages of addressing the areas for improvement such as general welfare and development. However, a number of the areas identified in previous inspections had not yet been fully addressed in a timely manner and remained in need of improvement.

The inspectors found that there had been some improvements in the staffing arrangements in the centre. Since the last inspection, the provider had reviewed the roster and systems in place to manage the vacancies and long-term absences. A number of staff nurses and multi-task assistants had been recruited to reduce vacancies and agency staff had been recruited to cover long term absences. However, continued work was required in this area to ensure a consistent care and support provided to residents. There remained a high reliance on agency staff to maintain the staffing complement.

In addition, staff training records were reviewed which indicated that the core staff team were up-to-date in the majority of training requirements. However, further work was required to ensure all staff including agency staff were suitably trained to meet the care and support needs of residents.

Regulation 15: Staffing

The provider had a planned and actual roster in place. The inspectors reviewed two months of rosters. The seven residents were supported by eight staff during the day and by three waking night staff at night. Occasionally, one night staff would be redeployed to another service and a risk assessment had been completed regarding this practice.

Consistency of the staffing complement had been highlighted in previous inspection reports as an area of improvement. This had been partly addressed. For example, the inspectors found that the provider had improved consistency of staffing by recruiting a staff nurse and multi-task worker to fill vacancies. The provider had also placed a regular agency staff to cover a long term absence to ensure continuity of care and support to residents. In addition, the provider informed the inspectors of recent national recruitment and upcoming plans for regional recruitment to fill the remaining vacancies.

However, there remained a high reliance on agency staff to maintain the staffing complement. This was impacting on the providers ability to meet the residents social care needs across all times of the day. For example, there was evidence that the provider had reviewed the roster and trialled reconfiguring one day shift to include later finishing times twice a week to support residents access the community and attendance at events of their choosing. However, the inspectors were informed that there were challenges in filling this shift due to the reliance on agency staffing.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The provider had identified the need for staff training in relation to meeting the social care needs of residents. From a review of staff training records, the provider had supported the staff team to attend person centred planning training. In addition, the inspectors were informed that training in social role valorisation was planned for early 2025.

The previous inspection identified that the records in relation to staff training for agency staff were not sufficient. Therefore the provider could not demonstrate that agency staff had the required skill set and training needs completed to effectively support the residents. On review of the records provided at the current inspection it was found that there were some improvements in this area. For example, the agency service providers had provided training details to the provider. However, some further work was required to review this information to ensure all agency staff working in this designated centre had completed the required training in supported eating, drinking and swallowing supports.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, there was an established governance and management structure in place. However, continued work was required to address the areas identified for improvement in a timely manner and to ensure the delivery of quality care and support to residents.

The inspectors found that the provider had implemented some actions outlined in the assurances provided to the Chief Inspector including:

- establishing a governance and oversight team, chaired by the Head of Service with terms of reference agreed to ensure the residents experience a good quality of life and specifically address the areas for improvement,
- quarterly audits by the Assistant Director of Nursing,
- the creation of an action monitoring log,
- supporting one resident to transition to an appropriate alternative placement,
- appointing a full-time, suitably qualified and experienced person in charge.

The service had developed a compatibility assessment for each resident to inform future de-congregation plans. However, on the day of the inspection only one plan was available for review.

There remained areas for significant improvement including premises, oversight of restrictive practices and residents rights. Continued work was required for systemic changes to embed and improve the overall lived experience for residents.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that the provider had taken some actions to address the areas of improvement identified in the previous inspections including fire safety and general welfare and development. In relation to positive behaviour support and the use of restrictive practices, resident's rights and presentation of the premises further significant improvements were required.

The inspectors found that there had been improvements in the general welfare and development of residents. The provider had completed an assessment of the residents interests and preferences. Personal goals were developed for each resident. The inspectors observed the residents accessing the community on the day of inspection. Records reviewed demonstrated that residents were accessing the community and engaged in local groups.

The systems in place for the oversight of restrictive practices required further improvement. The previous inspection identified night-time welfare checks were in place for all residents. Following a review, night time checks were required only two of the seven residents and had been discontinued for the remaining five residents. However, inspectors found that other restrictive practices in the centre required review.

In addition, some improvement was required in the systems in place for fire safety. Following the last inspection, a night time fire drill had been completed to demonstrate all persons could be safely evacuated from the services. However, the records for a subsequent night time fire drill required review.

Regulation 13: General welfare and development

The inspectors found that there had been increased focus and improvements for residents in their general welfare and development. The previous inspection found that residents health and personal care was met in this centre. However, the

complex physical and medical needs of residents left staff with limited time for social and activity based engagement.

The seven residents in this service did not attend any formalised day services or work during the day and are reliant on the staff team for activation. The inspectors reviewed personal goals and one month of activity records for six residents. Overall, there were improvements in social activities for residents which included engaging with local community groups, increased access to the community and the development of meaningful goals in line with the interests of residents. These plans were in the early stages of being developed and implemented so further work and time were required embed these practices in the centre.

Judgment: Substantially compliant

Regulation 17: Premises

The designated centre is a large purpose built premises located in a residential area on the outskirts of a town Co. Wexford.

Previous inspections have found that improvements were required in the condition of the flooring, painting and reviewing the premises in terms of its clinical presentation. Although there was evidence of some areas of the service with new flooring and aspects of the premises had been painted the works completed to date had not rectified the long standing issues to a meaningful degree.

As part of the written assurances submitted to the Chief Inspector, the registered provider outlined that they would replace the flooring in the laundry room, redecorate the dining room and address the peeling laminate on the kitchen cabinets. The provider had committed to have this work completed by October 2024. On the day of inspection this work remained outstanding. The inspectors acknowledge the plan to rectify the kitchen cabinets had expanded to include a the installation of a new kitchen which entailed additional planning. Although the work had not been completed the inspectors viewed evidence that tenders and funding had been approved for.

However, the inspectors found that the premises issues had not addressed in a timely manner. This meant residents were living in a clinically presented environment. For example the hallway leading to residents' bedroom was very bare in presentation, there were no pictures on display or decor present. As previously described the dining room was poorly presented with limited decor. Although functional in nature it did not present as a homely environment. This was found ot be presented in this manner over the last three years and limited actions had been taken to date on how to improve this environment.

In addition, exposed pipe work was noted in the dining room and bathrooms.The inspectors also found that the design and layout of a bathroom in the designated centre required some consideration. For example, the shared bathroom had two

doors - one which connected the bathroom to the hallway and the other to the laundry room. The laundry room door could not be locked and required review.

Residents spent significant periods of time in their home and do not attend a formal day service, therefore it was important that their environment reflected there individual preferences and was comfortable.

Judgment: Not compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. During the walk around of the centre the inspectors saw that the premises had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a personal evacuation plan in place which appropriately guided staff in supporting residents to evacuate.

The inspectors reviewed the fire drills that had taken place since July 2024. The provider had completed a night-time fire drill with the lowest number of staffing and highest number of residents which took approximately 17 minutes for a staged horizontal evacuation procedure. However, a subsequent night-time fire drill did not provide accurate assurances that the arrangements in place at night-time were appropriate to evacuate all persons in an effective manner. This drill which also occurred at night had a time recorded that was not reflective of the actual scenario. This did not provide assurances that staff were aware of the procedures to follow in the event of an emergency.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The oversight and use of restrictive practices in the centre required a number of improvements. On the walk around of the centre it was noted that number of external doors were on keypad locks. All locks were activated which meant that the door could only be used once the key code was entered. The provider reported that the key pad locks were only to be activated at night from 11pm to 8am for security measure. This was not occurring in practice and therefore a least restrictive approach was not demonstrated.

In addition, cupboards which stored chemicals both in a laundry room and kitchen were unlocked at the time of inspection. Risk assessments and restrictive practice records indicated that these storage presses should be locked at all times due to

identified risks. This was not occurring and therefore the need of the use of this restrictive practice was unclear.

In a residents bedroom, there was an audio visual alarm and a door alarm in place. There was no clear rationale in place why both measures were required as they seemed to serve the same purpose. Again it was not demonstrable that a least restrictive approach was been taken.

A full review of restrictive practices was required to ensure that they were in line with evidence-based practice and of a least restrictive nature.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents living in the centre had high care needs and required full support with all daily care needs. The number and needs of resident contributed to the lack of personalised daily activities and person centred care and a focus on immediate personal care. Although some improvements were made in this area through reduced resident numbers and an increased focus on daily activities, this remained an area for continued improvement.

The inspectors found that there were examples of an institutional approach to care in the centre. For example, as previously described residents were not afforded the right to privacy and dignity in terms of their individual bedrooms as bedroom door viewing windows remained partially uncovered. However, some staff spaces had window dressings applied to ensure that these spaces could not be viewed from the communal hall. This demonstrated that residents' rights were not central to all decisions being made in the centre.

On the day of inspection, on entering a resident's bedroom, their bed was making a beeping sound due to a malfunction of the associated equipment. When the inspectors asked how long the bed was beeping staff were unclear on this information. Maintenance records showed that the equipment had been identified as in need of review two weeks prior. While, this was addressed on the day of inspection and the bed was replaced, the timeliness of this action required review as the beeping had the potential to impact on the resident's right to sleep in a suitable environment.

The inspectors were informed of progress made in the modernisation of two bungalows which would support a further reduction in numbers of residents in this centre. The provider noted that it is estimated that the first bungalow would be available in April 2025 and highlighted the needs of residents in the wider service was being considered with the development of the two bungalows. Although this would be a positive development no finalised plans were available at the time of

inspection in relation to the transition of residents from the current designated centre.
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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Florence House OSV-0002632

Inspection ID: MON-0044719

Date of inspection: 02/12/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The roster was reviewed and an additional permanent staff nurse has been appointed to the Centre Further enhancements to the staff nurse roster will be completed following completion of the regional recruitment drive – interviews are scheduled for the week of the 3rd of February. A request for to run bespoke MTA campaign	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: SRV training for all staff in the Centre is scheduled to commence in Feb and run over a 3 week period Review of mandatory training for agency staff is undertaken with NOC with some engagement ongoing with CPL	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Compatibility assessments will be completed by 31/01/25 and will reflect the upcoming plan to downsize the Centre to 5 residents by 31/05/2025 Premises – All outstanding environmental enhancements will be completed by 31/10/25 Restrictive Practices – reviewed by PIC, restrictive practices have been reviewed and referrals made to RRC reflecting changes required. Staff have been informed of the need to adhere to restrictions in place for chemical press as per H&S Guidance.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: Staff continue to imbed recent learning and knowledge and strive to ensure improvements to increase community involvement and integration continue. Oversight by the PIC and PPIM is ongoing	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Flooring replaced in laundry in May 2024 Dining room – Redecoration and new furniture ordered New kitchen and utility presses installed 15/12/2024 In order to enhance the environmental appearance to the communal corridor and activation / MSR room a number of enhancements taking place and will be completed in Q1 2025 / 31/03/2015 Thumb lock installed on the bathroom side of the laundry room door which can now be locked to ensure privacy for residents when room is in use	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Simulated night time fire drill will be carried out monthly for next three months. Provider has arranged for personnel to carry out unannounced fire drill audit	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Restrictive Practices – reviewed by PIC, restrictive practices have been reviewed and referrals made to RRC reflecting changes required. Staff have been informed of the need to adhere to restrictions in place for chemical press as per H&S Guidance. Referral for 1 resident has been forwarded to RRC for review at their next meeting in March. In the interim the visual monitor has been removed from use and the staff have re-introduced hourly checks which have been identified as the least restrictive but safest method for ensuring safety of resident. Outstanding environmental enhancements will be completed before 31/03/2015	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Blinds for glass panels on doors have been ordered and will be installed by 31/01/2025 Fault on air mattress was rectified on 02/12/24. PIC spoke to staff to ensure any defects are reported in a timely manner to ensure no further such incidents As part of next phase of de congregation the Centre will downsize by 2 beds by May 2025.	

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 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.	Substantially Compliant	Yellow	31/03/2025
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	28/02/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	31/03/2025

	training, including refresher training, as part of a continuous professional development programme.			
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.	Not Compliant	Orange	20/05/2025
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/03/2025
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	31/03/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre	Substantially Compliant	Yellow	31/03/2025

	and bringing them to safe locations.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/01/2025
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	Yellow	31/01/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	31/05/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy	Not Compliant	Orange	31/01/2025

	and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			