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:	St. Vincent's Residential Services Group N
Name of provider:	Avista CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	27 June 2024
Centre ID:	OSV-0003172
Fieldwork ID:	MON-0043167

About the designated centre

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

St. Vincent's Residential Services Group N is a bungalow located in a campus setting on the outskirts of a city that can provide full time residential care for six residents of both genders over the age of 18 with intellectual disabilities. Each resident has their own bedroom and other rooms in the centre include a kitchen, a utility room, a dining room, two sitting rooms, bathrooms and a staff office. Residents are supported by the person in charge, nurses and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Thursday 27 June 2024	09:10hrs to 17:45hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Residents met during this inspection did not communicate verbally with the inspector or did not interact with him. Such residents did appear content and were seen smiling on occasions. The centre where residents lived was seen to be generally presented in a clean and homely manner although the flooring present was of an older style.

This designated centre was located on a campus setting and was linked to another designated centre via a locked interconnecting door. Five residents were living in the current centre at the time of the inspection. One of these residents was not present during this inspection as they had been staying with their family since the previous day although they were due to return to the centre later on the day of inspection. Of the remaining four residents, three of these were met by the inspector. Near the end of the inspection, the inspector did ask if he could meet the fourth resident but it was indicated that it was not the best time. As such this resident, while briefly seen by the inspector, was not met.

When the inspector arrived to commence the inspection, just one of the four residents present at that time was up. This resident was introduced to the inspector by a member of staff but did not interact with the inspector. The inspector was informed by this member of staff that the other three residents were in bed at this time. As the day progressed the inspector met two other residents after they had gotten up, one of whom got up shortly after the inspector arrived in the centre. While one of these resident was only met for a very brief period and both residents did not communicate verbally, the two residents were seen to smile on occasion while staff members on duty were warm and respectful in their interactions with residents. For example, a staff member praised one resident's appearance. Overall, throughout this inspection, the three residents met appeared content in their home environment.

The centre had access to some vehicles and as the day progressed, all four residents present left the centre at certain points. While away from the centre one resident had attended a medical appointment with a family member while another resident went to music therapy before going on a drive with staff and a resident from another centre on the campus. The inspector was informed that on this drive, the resident and their peer had been taken to get some ice cream. It was also indicated to the inspector that this drive was part of relationship building with a view to the resident of this centre and the resident of the other centre possibly living together in the future in a different setting away from the campus.

Early into this inspection management of this centre spoke of some training that they had completed which was intended to support residents to have quality transitions to other living environments. They further outlined how the provider had a wider strategic plan for the campus which involved the current residents of this centre ultimately decongregating (leaving the campus) and moving to community

based settings. As part of this the provider was actively seeking alternative premises to facilitate decongregation for two of this centre's residents. It was also intended that a third resident was to transition to the centre adjoining the current centre. This proposed transition be returned to later in this report.

The premises that made up the current centre was, for the most part, seen to be presented in a clean, homely, well-furnished and well-maintained manner. It was noted though that flooring in the centre was of an older style with the flooring in the larger sitting room in particular seen to be marked and worn. Some doors were noted to the marked also. Such observations had been evident during the previous inspection of this centre in September 2023. On the current inspection, the inspector was informed that the provider had a plan to replace the centre's doors while the flooring would be changed after one exit door had been replaced and works to a bathroom in the centre had been completed.

Works to this bathroom were nearing completion which involved the bathroom being changed into a wet room. Other rooms in the centre included a kitchen, a smaller room, a dining room, a utility room and a laundry room while each resident had their own individual bedrooms. Three of these bedrooms were seen which were nicely presented, furnished and personalised. For example, one bedroom was brightly decorated with photographs of the resident on display. It was seen that one of these bedrooms was furnished in a particular way which was related to the assessed needs of that resident. There was one vacant bedroom which was being used for storage at the time of the inspection.

The exterior of the centre was seen to be nicely presented which included the presence of potted plants and hanging baskets. This added to the homely feel of the centre. It was also seen by the inspector that at the front door of the centre there was a sign on display highlighting that the doorbell was to be used. During the inspection the majority of visitors to the centre noted by the inspector were seen or heard to use this doorbell before entering. One individual though was seen to enter the residents' home without using this doorbell or knocking on the front door. When queried, it was indicated to the inspector that this individual worked on the campus and staff had asked them to attend the centre. At the feedback meeting for the inspection, the inspector was informed that management had spoken to this individual about using the doorbell.

In summary, the staff members on duty were warm and respectful in their interactions with residents. Such residents were seen to smile at times and appeared content while the centre. All residents had their own bedrooms which were personalised or set up to the assessed needs of the residents. Overall, the centre was presented in a homelike manner.

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

Capacity and capability

Recommendations arising from a comprehensive assessment had, generally, been implemented. Some recommendations though were still be finalised or needed further review.

This designated centre was registered until September 2025 and had last been inspected by the Chief Inspector of Social Services in September 2023. That inspection had been used to seek more information regarding a significant incident that had been previously notified to the Chief Inspector pending completion of a comprehensive assessment into the significant incident by the provider. During the September 2023 inspection it was found that that provider had systems and structures in operation for the review and oversight of incidents this centre. However, improvement was identified regarding aspects of risk management, the notification of restrictive practices and meeting the assessed needs of one resident. Following the inspection, the comprehensive assessment was completed by the provider with a copy of this provided to the Chief Inspector along with an action plan. This action plan set out how the provider would address recommendations arising from the assessment. Such recommendations applied to all of the provider's designated centres. In the compliance plan response for the September 2023 inspection, the provider had indicated that the recommendations from this comprehensive assessment would be implemented.

On the current inspection it was found that, generally, the action plan as provided to the Chief Inspector was being implemented. This included completing particular audits. Some areas though, such as oversight of some induction records, did need further review as will be discussed under relevant regulations. In addition, formal policies on dysphagia and handovers, as recommended by the comprehensive assessment, had yet to be finalised although they were available in a draft format. Another recommendation was for there to be a review as to the adequacy of staff in centres for residents with high dependencies or high risk ratings with a due date of 30 September 2024. This applied to the current centre and on this inspection it was indicated that an external body had been identified to conduct this review but a start date for the review was unknown. As such it was unclear if the 30 September 2024 due date would be met but it was indicated that this centre would be the first centre to be reviewed. Other staffing related recommendations were around all staff completing training in areas such as risk management and dysphagia. While it was indicated that such training had been completed, the provider did have to be afforded two opportunities post this inspection to confirm this.

Regulation 23: Governance and management

In keeping with regulatory requirements a six monthly unannounced visit to this centre had been conducted in March 2024 by representatives of the provider. This

visit was reflected in a written report with an action plan in place to address any issues identified. Aside from the provider unannounced visit, the action plan for the comprehensive assessment had indicated that audits in areas such as feeding, eating, drinking and swallowing (FEDS), induction and handovers were to be completed. Documents provided during this inspection indicated that such audits had been completed. The comprehensive assessment action plan also indicated that an audit of risk assessments was to be completed during April 2024. During the inspection it was indicated that there was no audit tool for risk assessments but that a review of risk assessments had instead been completed by the health and safety officer for the campus. The inspector was also informed that matters related to risk had been considered as part of a health and safety audit that was completed in May 2024 with a copy of this audit provided.

Other recommendations in the comprehensive assessment related to handover process and induction. During the current inspection it was indicated that only staff nurses participated in handovers with a staff nurse spoken with during this inspection demonstrating an awareness of this process. Relevant training on handovers had also been provided to staff. It was also indicated that in the absence of centre management, a staff nurse would be the lead person on duty and would be responsible for assigning tasks to other staff. Regarding inductions it was seen that an induction folder was in place for the centre that contained key information about the running of the centre such a day and night profile for each resident and information about the centre layout. The comprehensive assessment had recommended new staff be inducted by senior staff on duty that all new staff sign the Induction folder to evidence that they have read and were aware of risks in the centre and their roles and responsibilities.

On the current inspection it was indicated that senior staff on duty did complete induction with new staff while induction records were available for individual staff to confirm that they completed induction. The inspector viewed all induction records for 2024 which indicated that keys matters such an introduction to residents, a tour of the centre, fire safety, risks, residents' FEDS programmes, emergency guidelines and reporting structures were covered with new staff upon starting. However, it was noted that recent induction records for two staff had not been signed off by the staff involved to confirm that the induction had been completed. In addition, some induction records had a signature space for management of the centre to sign off on the induction process. For recent induction records for three staff, management of the centre had not signed these as prompted. Other induction records did not have any space provided for management of the centre to sign off on the individual inductions. The action plan for the comprehensive assessment had indicated that management of the centre would oversee staff induction records.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Under this regulation, any restrictive practice in use in a centre must be notified to the Chief Inspector on a quarterly basis. The September 2023 inspection found that not all restrictions had been notified. Quarterly notifications of restrictive practices in the centre had been submitted to the Chief Inspector since then. However, the notification submitted for the first quarter of 2024 did not include the majority of restrictive practices in use in this centre. As a result restrictions such as key pads on some doors, the use of particular clothing for one resident and the use of chimes on bedrooms doors had not been notified. Such restriction were seen to be in use during this inspection and were included with the centre's restrictions documents while the inspector was informed that they were in use during the first quarter of 2024. Therefore, the requirements of this regulation had not been complied with although it was acknowledged that following the inspection the relevant restrictions were notified to the Chief Inspector retrospectively.

Judgment: Not compliant

Quality and safety

Matters related to relevant risks and FEDS programmes arising from the comprehensive assessment had been acted upon. One resident's current living environment did not suit their assessed needs, although a transition to another centre was intended.

The comprehensive assessment made a number of recommendations relating to risk management and residents' FEDS programmes. There were indications that such matters had been acted upon. For example, new locking mechanism had been introduced for some internal doors due to risk concerns, relevant risk assessments had been reviewed and updated while residents had been reviewed by a dietitian and a speech and language therapist (SLT) in recent months. As part of such reviews it was found that residents had relevant guidance in place related to their FEDS programmes. This included information about recommended modified consistency diets that residents were to receive, supervision needed during meal time and supports to residents in the immediate aftermath of residents having meals. While staff were aware of the presence of such guidance, the inspector did observe one instance involving a resident which needed further review in light of the resident's FEDS plan. For another resident it had been previously identified that the resident needed a different living environment than the one offered by their current centre. The provider was intending on transitioning this resident to the adjoining centre. This transition was intended as a stepping stone towards future community living away from the campus with notes of a multidisciplinary meeting from a March 2024 indicating that this transition could be successful. However, it did not appear that this transition would meet all previous recommendations made related to this resident.

Regulation 17: Premises

Overall, the premises provided for this centre was observed to be clean, homely, well-furnished and well-maintained manner. It was noted though that flooring in the centre was of an older style with some flooring, particularly in the larger sitting room, seen to be marked and worn. Some doors were also noted to the marked. While it was indicated that a plan was in place to replace to such doors and floors, similar observations had been made during the September 2023 inspection of the centre also.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Given the comprehensive assessment findings, this inspection found that key recommendations related to residents' food and nutrition had been reviewed. These included:

- Guidance on residents FEDS programmes (where applicable) were contained within residents' individualised personal plans and in a specific folder in the kitchen with staff aware of this.
- Residents had been recently reviewed by both a dietitian and an SLT around their diets and FEDS programmes respectively.
- Healthy eating plans were in place for residents.

However, the comprehensive assessment recommended that all FEDS plans for residents should clearly indicate the level of supervision required from staff including outside mealtimes. While residents' FEDS plans did provide guidance on supervision, when reviewing one resident's FEDS Plan it was read that it provided for the staff to be present during mealtimes and for the resident to remain upright for 30 minutes after their meals. The same resident was observed to be supported to commence a meal at 12:25pm on the day inspection. A staff member was present supporting the resident at this time which was done in a pleasant and unhurried manner. The resident finished their meal soon after but between 12:50pm and 1pm was seen to be on their own in the centre's larger sitting room without any direct staff supervision. One staff member did pass by this sitting room's doorway during this time period but it was unclear if they checked on the resident while doing so. As staff in the centre at this time were engaged in other tasks or supporting another resident, they could not ensure that the resident remained upright following their meal as outlined in their FEDS plan nor could they be present to offer assistance in an appropriate manner in the event that the resident was not upright. The resident was seen by the inspector to be upright during this time.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

This inspection's findings indicated that matters related to relevant risks arising from the comprehensive assessment had been acted upon. For example:

- Relevant risk assessments in the centre had been reviewed in recent months with particular risk ratings applied to certain identified risks.
- Where a near-miss incident of a particular type had occurred, this had been referred to a multidisciplinary team for review while a relevant risk assessment had also been updated.
- Where particular doors were required to be locked due to potential risks for residents, a keypad system was in place for such doors instead of keys and locks which had been present during the September 2023 inspection.
- Identified risks for residents were outlined in their individualised personal plans.

Aside from these, the comprehensive assessment had resulted in the provider issuing a safety alert to all of its designated centres on 15 March 2024 which outlined key issues related to a particular risk. A copy of this safety alert was present in the centre which included a signature sheet for staff to confirm that they had read the safety alert. Between core and regular relief staff for this centre, it was indicated to the inspector that there were 15 staff attached to this centre. Despite this, the signature sheet for the safety alert was only signed by 12 staff. In addition, a safety alert issued by the provider for a different risk that was also issued on 15 March 2024 was only signed by 10 members of staff. Neither safety alert staff had been signed by any staff member since 28 March 2024 so it was not documented if new staff who had commenced working in the centre since then had read these safety alerts. It was verbally indicated to the inspector that these safety alerts were covered as part of new staff's induction to the centre although this was not expressly indicated in induction records seen.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A resident currently living in this centre had been previously assessed as requiring an alternative living environment to better suit their needs. This matter had been specifically highlighted in previous inspections conducted by the Chief Inspector in May 2021, March 2022 and September 2023 with recommendations around this resident's living environment having been first made in 2019. Such recommendations indicated that the resident required a spacious area away from peers at particular times and that the resident could benefit from living with a small

group of others with a similar or higher communication ability to the resident in a home like environment with a large garden. At the time of the September 2023 inspection it was indicated that the provider was considering potential options for this and was reviewing this matter regularly. However, the provider's compliance plan response to this matter from the September 2023 inspection did not offer sufficient assurance that the provider would address this matter by 31 December 2024 as suggested. This was because the response provided appeared dependant on funding that had not been approved.

During the current inspection it was indicated that the provider was intending to transition the resident into an apartment in the centre adjoining the current centre. The inspector was informed that the resident was aware of this and that in moving to this apartment the resident would have access to a garden. Were the resident to move to the apartment in the adjoining centre, works would first need to be completed for the apartment which required funding. Notes of a June 2024 multidisciplinary meeting for the resident involved indicated that funding for such works were awaited. It was said to the inspector though that the proposed works for the apartments were being progressed and that the provider would proceed with these works even if funding was not forthcoming. When queried if the resident would be residing with others with a similar or higher communication ability to the resident in the adjoining centre, the inspector was informed that they would not be. However, it was highlighted that this resident's proposed move there was seen as a stepping stone to future community living away from the campus with notes of a multidisciplinary meeting from a March 2024 indicating that this transition could be successful.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Records were kept in relation to restrictive practices in use in the centre and it was seen that such restrictions were subject to multidisciplinary review. Other records reviewed also indicated that efforts were being made to reduce the use of some restrictive practices for two particular residents. When reviewing the individualised personal plan for one resident it was seen that they had a positive behaviour support plan in place which had been completed by a clinical nurse specialist. This plan provided guidance, including proactive and reactive strategies, on how to support the resident to engage in positive behaviour. A staff member spoken with demonstrated a good knowledge of this plan while incident records reviewed also indicated that it was followed.

Judgment: Compliant

Regulation 8: Protection

Guidance on supporting residents with their imitate personal care was contained within their individualised personal plans. Records provided indicated that staff had completed relevant safeguarding training. Since the September 2023 inspection, the Chief Inspector had been notified of one safeguarding concern related to this centre. During this inspection relevant documents were read indicating that this safeguarding concern had been appropriately screened with a safeguarding plan put in place. This safeguarding plan outlined measures to ensure the safety of residents involved. Such measures included positive behaviour support for one resident and all staff to be aware of the safeguarding concern. As highlighted under Regulation 7: Positive behavioural support, relevant guidance in this area was available for a resident involved. However, when speaking with two staff during the inspection, one demonstrated an awareness of the safeguarding concern notified, the other did not. It was acknowledged though that both staff displayed of a good general knowledge of residents and the supports they needed.

Judgment: Substantially 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 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for St. Vincent's Residential Services Group N OSV-0003172

Inspection ID: MON-0043167

Date of inspection: 27/06/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC and PPIM have reviewed the induction records for staff and all required signatures are now documented. The PIC will review the folder regularly to ensure that all staff induction records are completed in full.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC and PPIM will review the quarterly notifications in advance of submission each quarter to the Chief Inspector to ensure all restrictions are notified. Service Manager met with PIC and PPIM on 02/07/2024 to discuss the importance of having restrictions included on quarterly notifications.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: One exit door that required replacement has been delivered and awaiting installation by company, the company have confirmed date of installation of 09/08/2024. When this exit door is installed, the flooring will be replaced as flooring around the door frame will need to be altered.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: Clarity in determining the level of supervision and duration was sought from SLT and documented for each person. Support needs of this individual on reassessment have	

been seen to meet the requirement as recommended by SLT.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All staff working within the centre have read and signed both safety alerts. All staff who work in the centre are now required to read and sign the safety alerts even if already read and signed in another designated centre. The PIC and PPIM will review the signature pages to ensure this occurs when required.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PPIM and PIC scheduled a review of one resident's Individual Preference Needs and Assessment with the MDT on the 11.03.2024 where it was agreed that a move to adjoining centre, where an apartment was available, would be positive and best to meet resident's needs at this time. The recommendations were also raised at ADT. The provider has developed a time bound plan for the required works and a contractor has been identified who will complete the required works for the apartment. A transition plan for resident will then be in place to support this move to another designated centre for occupancy by 30/12/2024.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The PIC and PPIM will ensure that going forward safeguarding concerns will be discussed and highlighted at all staff meetings. Safeguarding concerns will continue to be highlighted during the centre's safety pause.

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 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	30/08/2024
Regulation 18(3)	The person in charge shall ensure that where residents require assistance with eating or drinking, that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.	Substantially Compliant	Yellow	17/07/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	28/06/2024

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	02/07/2024
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	02/07/2024
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that	Not Compliant	Orange	30/12/2024

	arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	02/07/2024