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:	Peamount Healthcare Neurological Disability Service
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	26 October 2023
Centre ID:	OSV-0003505
Fieldwork ID:	MON-0041755

About the designated centre

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

The aim of Peamount Healthcare's Neurological Disability service is to promote the long term physical and psychological wellbeing of all residents through consultation, co-operation, collaboration and communication with them, their families or advocate and healthcare staff. The centre provides continuing care services for up to 19 residents, who have prolonged disorders of consciousness, complex medical needs associated with a neurological disability and require 24 hour nursing support. The centre is based in a large campus setting, situated in a rural area of County Dublin.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 26 October 2023	07:30hrs to 17:00hrs	Karen Leen	Lead
Thursday 26 October 2023	07:30hrs to 17:00hrs	Erin Clarke	Support

What residents told us and what inspectors observed

This report outlines the findings of an unannounced risk-based inspection of this designated centre. The inspection was conducted to assess compliance with the regulations following the receipt of unsolicited information to the Office of the Chief Inspector. The inspectors were greeted on their arrival by staff members completing the night duty shift. Inspectors had the opportunity to sit with staff members during the daily handover of care from night staff members to day staff support members. Staff on duty made contact with the person in charge, who attended the centre later in the morning to support the inspection. The inspection was also supported by the director of nursing for periods throughout the inspection, who the provider appointed as a person participating in management (PPIM). Overall, the inspectors found that the provider had taken a number of responsive steps to bring about compliance with the regulations; for example, the provider had implemented a business case with its funder to increase the whole-time equivalence of staffing in the centre. However, the inspectors found that the insufficient staff resources in the centre were contributing to a negative effect on the residents' lived experience and quality of life.

This centre is operated by Peamount Healthcare and is situated on a campus-based setting in County Dublin with a number of other medical, rehabilitation and residential services. The designated centre is registered for a maximum of 19 residents. There are single occupancy rooms for 17 residents and one double occupancy room. At the time of the inspection, there was one vacancy in the centre.

As per the centre's statement of purpose, this centre provides services to residents diagnosed with neurological disabilities and, or prolonged disorders of consciousness following an acquired brain injury, spinal cord injury, and or complex medical needs with neurological disability that require 24-hour nursing support. Residents are assessed as having high maximum dependency needs, some of whom require specialist nursing input in the area of tracheostomy care, enteral feeding, epilepsy management, indwelling catheter care, bowel management, positioning and spasticity management. Residents are admitted under the care of a consultant in neuro-rehabilitation and have access to various multi-disciplinary team members, including occupational therapy, speech and language therapy, dietitians and physiotherapy.

The inspectors used observations and discussions with residents in addition to a review of documentation and conversations with key staff to form judgments on the residents' quality of life. The inspectors had the opportunity to meet with three residents and one family member during the course of the inspection. Due to their complex communication, some residents did not verbalise their opinions on care and support in the centre. The inspectors had the opportunity to observe interactions between residents and staff within the centre. It was observed that residents appeared relaxed, comfortable and enjoyed being in the company of staff members. Support staff were observed supporting residents to communicate using a number

of alternative systems. Inspectors observed staff to be tentative to residents' verbal and non-verbal communication needs throughout the course of the inspection.

One resident informed the inspectors that the staff in the centre were excellent and were very helpful. However, the resident told the inspectors that they were not happy living in the centre. They found that staff were always extremely busy and they did not want to disturb them when they were already doing so much. The resident informed the inspector that they would like to live somewhere that was not as busy and would give them more opportunities to go out in the community. The resident informed the inspectors that they get to go out for lunch and shopping but that, at times, this can not happen because the centre is busy or someone may be unwell. The resident told the inspectors that the staff do their best to support them; however, it is not the fault of the staff that some residents need more help than others.

The inspectors had the opportunity to speak to one family member. The family member told the inspectors that they are very happy with the support their loved one receives in the centre. However, the family had noted that lately, there has been a lot of relief or agency staff in the centre and that they have addressed their concerns with the provider. The family discussed that the support staff in the centre show great support not only to their loved one but also to the family as a whole and that they always feel welcomed when they regularly come to visit. The family member discussed that since their loved one was admitted to the centre, they have seen an increase in family-supported activities that require the support of staffing. These activities included shopping in the local shopping complex and visits home, which require a minimum of one staff to accompany.

The inspectors reviewed the centre's complaints log and the provider's unannounced six monthly audits. The documentation demonstrated families' dissatisfaction with the provider's increased use of unfamiliar agency staff and the impact that this was having on the continuity of care for their loved ones. The provider had responded to families in line with the complaints procedure and had completed a number of recruitment campaigns in an attempt to fill the current staff vacancies.

The next two sections of the report present the findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

This unannounced inspection was carried out in response to unsolicited information received to the office of the Chief inspector. A provider assurance report was issued to the provider in October 2023 after receiving unsolicited information regarding staffing levels in the centre. The inspectors found that the inspection findings largely substantiated the contents of the unsolicited information.

Following the submission of the provider assurance report, which included details on additional staff approved for the centre, the risk inspection was completed to monitor the assurances given. The inspectors found that while the provider had put in place a business case to increase the staffing resources in the centre in order to promote the quality and safety of care within the centre, improvements were required in relation to resources in the centre to ensure continuity of care for residents.

The management structure in the centre was clearly defined, with associated responsibilities and lines of authority. The person in charge was full-time, based in the centre, and they held responsibility for the day-to-day operation and oversight of care. The inspectors found that the person in charge had a clear understanding of the service to be provided and was fostering a culture that promoted the individual needs of each resident in the designated centre.

The provider had carried out six-monthly provider-led audits and an annual report of the service as required by the regulations. However, the six-monthly audit of care for the designated centre by the provider had failed to identify the impact that lack of resources was having on the centre or the completion of a business case by the provider in an attempt to secure additional funding for the recruitment of additional staffing to meet the assessed needs of residents. However, the inspectors acknowledged that the provider was actively escalating the increased support needs of residents and the requirement for additional staff, including nursing staff, healthcare assistants and ancillary staff such as social workers and allied health professionals.

The inspectors found that there was no evidence of a planned or actual roster available to staff in the designated centre. The provider had implemented a new rota system in September 2023, which held the staff rota electronically and was not accessible to all staff during the course of each shift or to provide an overview of the planned roster for the coming days. On the morning of the inspection, the inspector observed staff attempting to access the names and roles of staff members coming on duty via a telephone call to a member of the management team. There was no actual roster in place to identify staff members attending duty over a 24-hour period. Furthermore, staff could not identify from the electronic rota if a vacant shift had been covered for the coming days or the staff member's name or role assigned to the vacant shift. From speaking with the provider, they were aware of the difficulties the new online rostering system was causing staff and the impact it was having on ensuring compliance with regulations. The inspectors were informed this matter had been raised with the external company responsible for the software for correction.

The inspectors requested Schedule 2 files for a number of staff working in the centre. These files contain legally mandated information to be held for all staff working in a designated centre, including Garda vetting, photographic identification and qualifications. While the provider had a clear system in place to maintain these records for permanent and relief staff, a similar system had not been established for agency staff records and, therefore, did not have access or oversight of these

records.

A review of the staff training matrix identified that staff had access to a high level of mandatory and refresher training. There were adequate arrangements in place to monitor staff training needs and to ensure that adequate training levels were maintained. Staff received training in key areas such as safeguarding adults, fire safety and infection control. Staff also received training in areas specific to residents' assessed needs, for example, tracheostomy care, enteral feeding and epilepsy training. In addition to specific training for staff, the provider had provided additional support to the designated centre through a clinical nurse specialist to ensure resident safety during periods of high levels of agency staff nurses. This support ensured that residents' assessed needs in specific areas, such as tracheostomy care, could be completed, promoting residents' safety.

There was a clear complaints procedure in place. Complaints were managed in line with the organisation's complaints policy. Records indicated that where a complaint was made, considerable effort was taken to address areas of concern, and complainants were notified of the outcome of complaints made. The complaints procedure and details of advocacy services were displayed in the centre.

Regulation 14: Persons in charge

There was a person in charge of the centre who was a qualified professional with experience of working in and managing services for people with disabilities. They were also found to be aware of their legal remit with regard to the regulations, and were responsive to the inspection process.

Judgment: Compliant

Regulation 15: Staffing

There was evidence of negative outcomes for residents due to staff shortages and vacancies identified within the designated centre. The provider had carried out an assessment of need for residents in conjunction with the service's funder, which included a review of the staffing requirements in April 2023. However, the results of the review were not yet made available to the provider. While awaiting the recommendations of the review, the provider implemented a provider-led business case for additional staffing in order to promote the quality and safety of care for residents in the centre. However, as the designated centre had a number of pre-existing vacancies, the inspectors found that the centre was reliant on a high number of relief and agency staff on a weekly basis to cover staff vacancies. This did not support continuity of care for residents in line with their assessed needs. Inspectors found that the staffing vacancies were leading to additional risks in the

designated centre, such as increased time required to complete medication administration.

The inspectors found that there was no evidence of a planned or actual roster available to staff in the designated centre since the introduction of the new rota system in September 2023. When requested, the rosters were printed for the inspectors for review. However, as previously discussed, since September 2023, staff in the centre did not have access to the planned and actual roster for the designated centre. The centre was reliant on a high number of agency and relief staff, with the inspectors finding evidence of shifts that could not be filled by the provider or required the support of the person in charge to cover the centre to ensure appropriate staffing levels were maintained. The roster did not demonstrate when staff were on leave, if the shift had been covered, or the name and title of the staff on duty. For example, on the day of inspection, the planned roster provided to the inspectors did not demonstrate the shift that required covering for the coming day due to staff leave.

Furthermore, on review of the local induction of agency staff to the centre, the inspectors found from January 2023 to the day of the inspection, nine local induction forms were completed for agency healthcare workers and five local induction forms were completed for five staff nurses. This was despite the high reliance on agency staff used in the designated centre; for instance, the centre required 28 agency staff from the 16th of October 2023 to the 23rd of October 2023 in order to fulfil the required staffing levels as per the provider assurance report completed by the provider.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had ensured staff had access to training and development opportunities in order to carry out their roles effectively. Training was made available in areas specific to residents' assessed needs.

Judgment: Compliant

Regulation 23: Governance and management

For the most part, there were satisfactory local governance and management systems in place in the centre that ensured the service provided was safe and effectively managed. However, the inspectors found there was insufficient resources available in the centre to met the needs of residents. The lack of resources was

having a adverse effect on residents quality of life.

The provider had completed an annual review of the quality and safety of the centre, however there was no evidence of consultation with residents, their representation or staff.

While the provider had completed unannounced visits to the centre the inspectors found that the most recently completed six monthly unannounced visit to the centre had not identified the concerns highlighted by the provider which lead to the completion of a business case to increase the whole time equivalence staffing for the centre in order to met the assessed needs of residents

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints policy for the centre. An easy-to-read version of the complaints procedure was located in an accessible place.The complaints policy and procedure included information for residents on how to access advocacy services. There was evidence that where complaints were made that these were investigated promptly and that the complainant was informed of the outcome of their complaint. The person in charge maintained a record of any complaints, and there was a review mechanism as part of the written complaints procedure.

Judgment: Compliant

Quality and safety

This section refers to the quality and safety of care being provided to residents. Taking into account the risk-based element of this inspection, risk management and the assessment of the needs of residents were the primary focus under the quality and safety regulations. The inspectors found that the person in charge and the provider were aware of the risks in the centre and used this data as part of their business case to highlight the additional resources required in the centre.

The inspectors completed a walk-through of the centre in the company of the person in charge. The centre is a single-storey building divided into two corridors, one for male residents and one for females. The entrance lobby contained two living rooms, a large open-plan dining room and a lounge area. There was a kitchen, four shower rooms, two toilets, a staff office, two staff toilets, a staff changing room, a staff lunch room, a laundry room, a sluice room, and storage rooms. A multi-purpose therapy room is also provided, which facilitates allied health treatments as

required on a scheduled basis.

As highlighted earlier, it was also evident that there was an impact on the under-resourced staffing whole-time equivalence (WTE) was having on residents and their families. Due to the acquired nature of residents' complex and intricate needs, there was a clear need for additional social work contact hours in order to provide effective and timely support for residents who had a range of family representatives, including parents, spouses and children. The social work WTE for the centre was 0.1 for 19 residents. At the time of the inspection, a portion of residents were on a waiting list for a social worker.

The centre's risk register had been recently reviewed and was found to be an accurate reflection of the risks presenting. Individual risk assessments were available as required. Inspectors found that the person in charge was identifying the lack of resources in the centre which was leading to higher risks for residents and impacting on residents overall lived experience For example, the person in charge had identified the risk in relation to the reduction in social interactions for residents as a result of increase use of agency and relief staff. The person in charge had also identified that scheduled tasks in the centre such as medication rounds was taken significantly more time due to lack of resources and this was having a negative impact on residents supports.

Regulation 26: Risk management procedures

The provider had systems in place for the ongoing management and monitoring of risk. The person in charge held responsibility for managing risks within the centre, and comprehensive risk assessments were in place for issues which had the potential to impact upon residents' individual safety or the overall delivery of care. Risk assessments were subject to regular review, and they were also amended to reflect where changes in care had occurred. The centre's risk register was reviewed by the inspectors and it was found to be an accurate reflection of the known risks in the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had identified that the centre, which had evolved over the previous years to support higher-dependency residents, no longer met the needs of one resident who wanted to live more independently in the community. The inspectors were updated with a transfer plan to a community house that was being reviewed at a senior management and board level due to some complexities within the housing requirements. While this would have a positive impact for the resident, there was no

time-bound plan in place for the transition. The registered provider had not ensured that adequate arrangements were in place to meet the assessed needs of each resident. Inspectors found that the staffing vacancies were leading to additional risks in the designated centre, such as increased time required to complete medication administration and delays in accessing social work services.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Peamount Healthcare Neurological Disability Service OSV-0003505

Inspection ID: MON-0041755

Date of inspection: 26/10/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
There are 2 full-time nurses that have been recruited for the centre, both staff will be commencing in December while a 3rd staff nurse has been recruited they are going through compliance checks. 3 relief staff have taken a line on the roster to cover shifts until permanent staff can be recruited, this commenced 13/11/2023. This will reduce the requirement for agency/unfamiliar relief staff. Recruitment has been ongoing but is on hold due to the HSE Moratorium, a recruitment open day was held in early November which proved very successful, recruitment open days will be scheduled quarterly for 2024 when the HSE lifts the recruitment embargo. Due to the HSE embargo on all recruitment for health and social care the Provider cannot recruit until the embargo has been lifted. Where possible we will seek exemptions to the embargo through the HSE for vacant posts.
The actual roster is now saved in PDF format on the K drive where all staff can access this in the absence of the manager, this will be saved regularly to ensure it is up to date. Discussions have been ongoing with Softworks (IT Roster system) to develop access to actual rosters for all staff in the absence of the manager. A CNM2 has been allocated to support the eRostering system and the further development of the system which will commence in December 2023.

Staff responsible for booking agency staff now request the agency's HIQA compliance pack for each staff member, to include Garda vetting, Qualifications, mandatory training and confirmation of PIN/registration with NMBI and when received this is maintained with Nursing Administration, we are continuing to work with agencies to ensure this process is in place.

Local inductions are now completed with all agency staff and unfamiliar relief staff with all records maintained of induction process, this was implemented with immediate effect following feedback of inspection.
The Provider has issued a business case to the funders (HSE) for a new admission, for any new admissions funding for staffing must be part of the admission/referral process

and agreed prior to transfer.

*A completion date for compliance has been set at the 31/03/2024, this date is greatly impacted by the HSE recruitment embargo. We will continue to endeavor to recruit into vacant posts as soon as the embargo is lifted, in the meantime we will process new staff who are going through compliance checks.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Annual reviews will include consultation with residents, their representatives and staff, this will be recorded in all relevant areas of the review.
The 6 monthly reviews will include any concerns highlighted by the Provider and any actions in progress to address concerns.

The Provider has issued a business case to the funders (HSE) for a new admission. The business case clearly outlines the funding for staffing that must be part of the funding for the admission and agreed prior to transfer.
The Provider reviewed the skill mix and assessed needs of the residents in St Bríds in October 2023, the outcome identified the requirement for an additional 2 WTE nurse and 4 WTE CA due to an increase in dependency of residents in the centre. Recruitment of these posts has been ongoing. There are 2 full time permanent nurses commencing employment during December 2023, a 3rd staff nurse was recruited in November 2023 and is currently undergoing compliance checks, further staff redeployment is in progress with 1 WTE Care Assistant vacancy being filled in December 2023. 3 relief staff have a permanent line on the roster to ensure continuity & safety of care provided and improve resident's quality of life, this will continue until the permanent posts are recruited. Recruitment is ongoing but due to the HSE embargo is on hold at present.

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:
Following a review of staff numbers and skill mix in October 2023 the outcome identified the requirement for an additional 2 WTE Nurse and 4 WTE Care Assistant. 2 Staff Nures are commencing in December along with a further 1 WTE Care Assistant. We will continue to endeavor to recruit vacant posts as soon as the HSE recruitment embargo is lifted, in the meantime new staff are being processed through compliance and redeployment within the organization.

One resident has expressed their wish to move from St Bríds into a Peamount Community Bungalow, this has been discussed with the resident, reviewed by MDT, and discussed at the transfer committee meeting, all have agreed that this resident will be supported to move to a Community Bungalow. The resident visited their new home on 16/11/2023 and staff are planning the transition safely for all residents involved, this will include daytime trials and overnights over a period of time until all residents are

comfortable with the move. The resident moving out of St Brids is satisfied with the progress and is updated on a regular basis, as above the move will be completed over a phased basis.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/03/2024
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.	Not Compliant	Orange	31/01/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	31/01/2024

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	31/01/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	29/02/2024
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	29/02/2024
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	29/02/2024

Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	29/02/2024
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/01/2023
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal	Not Compliant	Orange	31/03/2024

	development in accordance with his or her wishes.			