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:	No 2 Cordyline
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	08 April 2024
Centre ID:	OSV-0004594
Fieldwork ID:	MON-0034339

About the designated centre

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

No 2 Cordyline is based on a campus setting located in a rural area but within close driving distance to some towns. The centre can provide full-time or part-time residential support for a maximum of 21 residents, of both genders over the age of 18, with intellectual disabilities and those who present with multiple and complex needs. The designated centre consists of five bungalows and one apartment area. One of the bungalows is set up to provide individualised living arrangements for two residents while the other bungalows can provide a home for four or five residents. The apartment area supports one resident only. All residents have their own bedrooms and other rooms throughout the buildings that make up this centre include kitchens, living rooms, bathrooms and staff rooms. Residents are supported by the person in charge, team leaders, nurses, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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 8 April 2024	08:50hrs to 20:15hrs	Conor Dennehy	Lead
Monday 8 April 2024	11:45hrs to 20:15hrs	Laura O'Sullivan	Support

What residents told us and what inspectors observed

Feedback received during the inspection process was mostly positive. However, some areas were highlighted relating to issues including bedrooms, living arrangements and staffing. Staff members on duty were seen to interact appropriately with residents.

This centre was comprised of five separate bungalows and one apartment area located in close proximity to one another on a campus setting. One of the bungalows was set up to provide individualised living arrangements for two residents setting while other bungalows could provide a home for up to five residents. Combined these bungalows and the apartment could provide a home for a maximum of 21 residents. One the day of this inspection 17 residents were present in the centre, another resident was away from the centre staying with their family and there were three vacancies. Inspectors visited five of the six buildings that made up this centre and met 13 residents in total during the inspection.

As this inspection had been announced four weeks in advance, residents had an opportunity to complete surveys on the lives that they experienced while living in this centre. Such surveys asked questions around the residents' home, the staff support they received, how residents had a say in their home and what residents did every day amongst other topics. On the day of inspection, inspectors were provided with 14 surveys with four more surveys provided in the days following the inspection. For five of these surveys, residents had received help from a relative in completing them while for the remaining 13 surveys, residents had been helped by staff members to complete them. Most surveys provided generally contained positive responses to all areas raised. Specific comments included in such surveys included "I like having my own big bedroom and my own television" and "my lifestyle has been completely changed for the better".

One survey described a resident as being "extremely happy" living in the centre while another made reference to there being "excellent care" provided. However, areas for improvement or concerns were raised in some surveys. One such survey stated that "I would like a bigger bedroom" while another survey referenced that a different resident would prefer to live with people their own age or have an apartment. This latter point was referenced in a further survey that was completed for the same resident which also raised concerns in other areas including the resident's bedroom, the bungalow where this resident lived, the availability of staff support and activities being cancelled on account of staffing. Another survey for a third resident referenced the resident wanting to go out more with staff and there being lots of new staff that the resident did not know.

The staff members on duty during this inspection were observed and overheard to interact with residents in a caring and warm manner during the inspection. For example, when one resident was about to start writing in a book, something which they liked to do, a staff member brought the resident various pencils and pens to let

the resident choose what they wanted to write with. On another occasion, a different member of staff observed that a resident needed some support and immediately provided this to the resident. Residents were also seen to be comfortable in the presence of the staff supporting them. It was noted though during the inspection that one resident was supported by staff to change into their pyjamas at 5:15pm. While this was indicated to be to support the resident's needs, this was not clearly outlined in the resident's personal plan.

While the resident and staff interactions encountered on the day of inspection were positive and respectful, it was identified during this inspection that some resident were receiving checks in their bedrooms at night. Such checks had the potential to impact residents' privacy but the rationale for such checks was not always documented. For one resident it was indicated that they were to receive such checks due to possible seizures. However, the same resident had a bed senor already in place related to this so it was unclear why the night checks were needed with this. Aside from this, on one occasion a delivery person to one bungalow was observed to enter without knocking or using the doorbell first. This also had the potential to impact residents' privacy in their home. It was seen though in a different bungalow that other visitors to that bungalow did knock or use the doorbell before entering.

The residents that inspectors met during this inspection, did not all communication verbally and some did not engage directly with inspectors. However, some residents did greet inspectors and/or speak with inspectors. Such residents generally provided positive feedback and appeared happy in their homes. For example, one resident showed the inspector their bedroom and some watches they had in the presence of a staff member and seemed happy while doing so. All residents living in this centre had their own bedrooms, some of which were seen by inspectors. Such bedrooms were noted to be nicely furnished and personalised with wardrobes provided to store their personal belongings. It was seen though that one resident's wardrobe was labelled for different types of clothes. Some residents also had fitted wardrobes. While most residents did not pay for these, it was indicated that one resident's funds were used to pay for their wardrobe. This will be discussed further below in the context of Regulation 9 Residents' rights.

It was also observed that the doorframe of one resident's bedroom was narrow for the wheelchair that they used with an inspector observing that moving this wheelchair through the doorframe took some time as a result. Management of the centre indicated that this was caused by a recent wheelchair change and that some doorframes in the bungalow where the resident lived were due to be widened on account of this. In the months leading up to this inspection, the provider had finished premises works in one of the bungalows to support two residents to have individualised living arrangements in order to better meet their needs. This bungalow was visited by an inspector which was noted to be very homely and well-furnished in its appearance. The other bungalows and apartment seen by inspectors were generally well-presented and clean also.

However, as had been also noted on a previous inspection in February 2023, communal space was limited in some bungalows given the number of residents living there while in such bungalows a space was not available for residents to

receive visitors in private other than the residents' bedrooms. It was acknowledged that residents of this centre did have access to a nearby building on the same campus that could be used for residents to receive visitors in private if they wished. While this building did not form part of the designated centre, its use was referenced in both the centre's statement of purpose and residents' guide. Despite this, the suitability of this arrangement was raised by a family member met during this inspection who highlighted that it would not always be appropriate to bring their relative to this building depending on the weather. As a result, the family member highlighted how if they wanted to have private time with their relative in the resident's home, they would have to do so in the resident's bedroom.

The same family member spoke positively of some staff supporting their relative but did highlight that they did not always know the staff on duty. The multidisciplinary team supporting this resident were commented on positively by this family member but they make reference to queries that the family member was making not being responded to by management of the centre. In addition to these points, the family member spoken with raised concerns around the living environment for the relative in their current home along with the availability and levels of staff provided to support the resident in their home and to do activities. In doing, so it was also highlighted that the resident had only recently had a personal-outcomes measures (POMs) process completed to identify goals for the resident to achieve. This was despite the resident not having a day service and having been living in the centre for some time.

Residents were supported to engage in a POMs process at the time of this inspection although as will discussed further below some improvement was needed in this area. Inspectors had been informed also that most residents in this centre did have access to day services. During the day of inspection, some residents were seen leave their home to attend these day services which were located on the campus grounds. In one house though, an inspector did overhear a conversation between staff suggesting that a resident could not go to their day service on account of the weather. When reviewing activity records for some residents, these suggested that some residents did not do many activities away from the campus. When queried, it was highlighted by one staff member that residents would participate in activities away from the campus through their day services. Inspectors were informed that sufficient transport was available to facilitate activities away from the centre although some documents reviewed during the inspection did make reference to some transport issues.

In summary, the buildings visited during this inspection were generally seen to be reasonably presented including residents' bedrooms. From complete surveys and residents met during this inspection, feedback received was mainly positive. However, some surveys did highlight some issues as did one family member met during this inspection.

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

While there had been some improvement since a previous inspection, a number of regulatory actions were found during this inspection. This indicated that the management systems were not operating effectively for the centre. It was acknowledged though that some inspection findings were contributed to by staffing challenges encountered by the provider.

This designated centre was registered without any restrictive conditions until September 2024 and had last been inspected by the Chief Inspector of Social Services in February 2023. That inspection had found a notable increase in the amount of regulatory actions compared to previous inspections with particular concerns identified around monitoring systems, oxygen storage, staff supervision and positive behaviour support. Following that inspection the provider submitted a compliance plan response outlining the measures that they would take to come back into compliance. Since then, in March 2024, the provider had submitted an application to renew the centre for a further three years beyond September 2024. The purpose of the current inspection was to assess progress made since the February 2023 inspection and to determine the compliance levels in more recent time to inform a decision on the renewal application.

During the current inspection, it was found that there been improvement in some areas including oxygen storage and positive behaviour support. However, a number of regulatory actions were again found with particular concerns identified around aspects of personal planning, the premises provided to meet residents' needs and fire evacuation from one bungalow. Such matters will be discussed further elsewhere in this report. Overall, regulatory actions were identified in the majority of regulations reviewed during this inspection and, taking into account the findings of the February 2023 inspection, the compliance levels in this centre had notably deteriorated in the centre's current registration period. As such, given the overall findings of this inspection, inspectors were not assured that the management systems in operation for this centre had ensured that the centre was safe, appropriate to residents' needs and effectively monitored. It was noted though that a contributory factors to some of the findings of this inspection was staffing challenges being encountered by the provider.

Such challenges had resulted in there being fewer team leaders working in the centre then planned with such team leaders intended to play key roles in the operations and oversight of individual bungalows. It was acknowledged though that there was a general staffing crisis affecting the health and social care in Ireland and the provider had been making ongoing recruitment efforts. During the introduction meeting for this inspection, an inspector was informed by management of the centre that the staffing challenges encountered had limited the ability of the provider to

focus on quality improvement initiatives for the centre. It was highlighted though that there was an upcoming management change for the centre, while the provider had also secured a community based house. This house was intended to be used for decongregation purposes and it was possible that up to three residents from this centre could ultimately avail of this community house subject to further planning and consultation.

Regulation 15: Staffing

In keeping with the requirements of the regulations, staffing in a centre must be in keeping with the needs of the residents and a centre's statement of purpose. According to this centre's statement of purpose, staffing in the centre was to be provided by mixture of team leaders, nurses, social care workers and care assistants. At the outset of this inspection it was highlighted that there were vacancies in such posts. A risk related to staffing had been escalated within the provider and efforts were being made to recruit for more staff and minimise the impacts. Despite these, inspectors were provided with examples of the effects of such staffing challenges. These included;

- Two bungalows of this centre did not have team leaders in place which had been the case for some time.
- There had been some occasions when staff levels were lower than required.
- Some nursing shifts could be filled by care assistants.
- An activity not being able to happen on a particular day due to a lack of staff.
- Feedback received from staff members indicated that it was hard to do different POMs goals with residents giving staffing pressures.

As such, at the time of this inspection, staffing in this centre was not in keeping with the needs of the residents nor the centre's statement of purpose.

Judgment: Not compliant

Regulation 16: Training and staff development

The provision of staff training and staff supervision had been flagged as areas for improvement during the two previous inspection of this centre in April 2021 and February 2023. While there had been some improvement in these areas since the February 2023 inspection, on the current inspection it was indicated that 37% of staff working in this centre had not received supervision in line with the provider's policies while there was some training gaps in areas including personal protective equipment and manual handling. Some variance was also noted in how staff meetings were conducted and how often they took place.

Judgment: Not compliant

Regulation 22: Insurance

The provider had ensured that appropriate insurance arrangements had been put in place for this centre.

Judgment: Compliant

Regulation 23: Governance and management

While the provider was monitoring the service provided in the centre and there had been improvement in some areas since the February 2023 inspection, during the current inspection regulatory actions were identified in the majority of regulations reviewed. Such findings did not provide assurances that the monitoring of the centre was ensuring that all relevant matters were identified and addressed in a timely manner. The regulatory actions identified on this inspection included particular concerns being identified around aspects of personal planning, the premises provided to meet residents' needs and fire evacuation from one bungalow. Such matters had the potential to adversely impact the quality and safety of care and support provided to residents. The overall findings of this inspection did not provide assurance that the management systems in place for this centre had ensured that the centre was safe, appropriate to residents' needs and effectively monitored.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Under the regulations, the provider must agree upon residents' admission to the designated centre, a contract that sets out the services and supports to be provided to the residents while they live in the centre. Most residents did have contracts in place while it was indicated that the provider was in the process of updating such contracts. However, during this inspection it was identified that one resident did not have an agreed contract in place while the contract for another resident related to a different designated centre. A third resident's contract referenced the resident living in one bungalow of the centre but at the time of this inspection they were living in a different bungalow.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was in place that contained all of the required information such as details of the criteria for admission, the centre's organisational structure and the arrangements for dealing with complaints. This statement of purpose had been reviewed within the past 12 months and copies of this were seen to be present in the buildings visited.

Judgment: Compliant

Regulation 34: Complaints procedure

Information about the complaints process was seen to be on display in the bungalows of this centre. While the provider did have processes for recording and responding to complaints, it was noted that the complaints records in place did not always document how the complaints had been resolved.

Judgment: Substantially compliant

Quality and safety

While there was evidence of good supports found in some areas, improvement was needed in other areas. These included fire evacuation from one bungalow and the premises provided to meet the needs of some residents.

During the previous inspection in February 2023, concerns were raised from a fire safety perspective relating to the storage of oxygen in some of the bungalows of this centre. Such storage was found to have improved on the current inspection with oxygen kept seen to be stored behind fire doors. Such fire doors were one of the fire safety systems that were present in the buildings of this centre which also included emergency lighting and fire extinguishers. Residents had personal emergency evacuation plans outlining the supports they needed to evacuate the centre if needed while most staff had completed fire safety training. However, in one bungalow a fire drill record was seen from February 2024 which indicated in a 10 minute evacuation time for a drill during the day time even though it was indicated that evacuation times of three minutes were aimed for. Despite this, management of the centre appeared unaware of the evacuation time recorded in this drill until it was highlighted by an inspector on the day of inspection. It was subsequently indicated to inspectors during the feedback meeting for this

inspection, that a further drill would be conducted the day following this inspection.

The outcome of this drill, which reflected a day time situation, was subsequently communicated which indicated an evacuation time of seven minutes and 49 seconds. While this was an improvement and it was indicated that further drills were to be conducted, the evacuation times recorded for the two drills referenced did not provide assurances that all residents living in this bungalow could be evacuated in a safe time if needed. Given that neither of these two drills reflected night-time situation, this was a further concern given that evacuations in the event of a fire at night when all residents would be bed could take longer given the needs of the residents living in this bungalow. For example, two residents in this bungalow would require hoisting and the support of two staff to evacuate when in bed. It was also concerning that management of the centre appeared unaware of the evacuation time of the February 2024 drill, given the risks associated with fire safety. The nature of such concerns prompted the Chief Inspector to seek further assurances around fire evacuation for all residents from this bungalow in the days following this inspection. The response received indicated that a further drill had been conducted on 12 April 2024 with a five minute 46 seconds evacuation time indicated. While this was lower, it was notable that this drill only involved three of the four residents living in this bungalow although further drills were planned.

Aside from this, it was noted that residents living in this centre had personal plans in place. Such plans are intended to set out the assessed needs of residents and how to provide for these needs. Providers are also required to ensure that appropriate arrangements are in place to meet the assessed needs of the residents and that the premises provided are suited to meet the assessed needs of residents. Inspectors reviewed a sample of residents' personal plans which were subject to multidisciplinary input while the contents of such plans were recently marked as reviewed and did provide good guidance in some areas, improvement was needed though to ensure that they provided clear guidance for all of residents' needs. POMs processes had been completed for residents, as outlined in their personal plans, but it was noted that such a process had only been recently completed for a resident who had been living in the centre since 2022. Goals identified for other residents were noted to very similar and in some instances the goals were things that residents were already doing. In addition, when reviewing the personal plans of two residents, it was read that both explicitly highlighted that the residents' current residential setting was not suited to their needs. This related to the both resident's current living environments and the premises provided.

Regulation 11: Visits

Some of bungalows where multiple residents lived together, did not have sufficient space for residents to receive visitors in private aside from their bedrooms. While it was acknowledged that residents did have access to another building on the campus that could be used to receive visitors, a family member highlighted that it would not always be appropriate to bring their relative to this building depending on the

weather.

Judgment: Substantially compliant

Regulation 17: Premises

The buildings visited by inspectors were generally well-presented and clean. Some of bungalows where multiple residents lived together had limited communal space. Since the previous inspection, works had been completed in one bungalow to provide two individualised living arrangements for one resident each. These was better suited to the needs of the residents living in these apartments. However, while the provider had made efforts to ensure that the needs of all residents were met and was continuing to do so, two residents' personal plans stated that that these residents' current residential setting was not suited to their needs. This related to the both residents' current living environments and the premises provided for them.

For one of these residents' their personal plan stated that they needed a bigger bedroom with a wet room attached. This resident, who was a wheelchair user, currently lived in a bungalow with three others and a multidisciplinary assessment from November 2022 highlighted that the resident could benefit from a single occupancy living arrangement. It was also observed that doorframe of this resident's bedroom was narrow for their wheelchair that they used. For the second resident a report had identified that the physical environment provided by the resident's current home was not suited to support both the resident and the staff who would ordinarily be working with the resident. This meant that such staff occasionally had to leave the resident's home due to the presentation of the resident or do conduct certain tasks for the resident such as preparing a meal. The same report highlighted that staff having to come and go from this resident's current premises did not lend itself to a sense of home.

Judgment: Not compliant

Regulation 20: Information for residents

A residents' guide was in place that contained all of the required information such as details about the complaints process and how to access inspection reports.

Judgment: Compliant

Regulation 26: Risk management procedures

Given the evacuation time recorded for a fire drill in one bungalow in February 2024, it was of concern that management of the centre did not appear to be aware of this until highlighted during this inspection. In addition, at the time of this inspection no fire drill had completed in this bungalow since then to determine if residents could be evacuated in a quicker time. Given the potential risk related to fire and long evacuation times, this did not provide assurances that the risks related to the recorded evacuation time in February 2024 had been appropriately escalated nor that sufficient measures had been considered to reduce the potential risks at the time of inspection. This is addressed in the context of Regulation 28 Fire precautions.

Risk assessments were seen to be in place outlining control measures, risk ratings and risk owners for risks. However, it was seen that the content of some risk assessments needed updating to ensure that they reflected current information. For example, for one risk assessment it was seen that the risk owner had not been updated to reflect a change while one resident's risk assessment for falls indicated an increased likelihood of falls even though an inspector was informed that the resident had not had a fall for over five years.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Some of the residents who lived in one bungalow were highlighted as needing two-to-one staff support and hoisting to evacuate the centre. While it was indicated that an evacuation time of three minutes was aimed for, a February 2024 fire drill for this bungalow indicated an evacuation time of 10 minutes. This did not provide assurance that all residents could be evacuated from this bungalow in an adequate time. While a fire drill was conducted following this inspection, the stated evacuation was 7 minutes and 49 seconds which also raised concerns around the evacuation arrangements for the bungalow. Given that both of these drills appeared to reflect a day time situation, further assurances were needed to ensure that residents could be safely evacuated from this bungalow both during the day and at night.

As residents in this bungalow would be bed at night an evacuation could take longer given the needs of the residents living in this bungalow. The previous fire drill to reflect a night-time situation for this bungalow had been conducted in June 2023. While the evacuation time for the June 2023 fire drill indicated a lower evacuation time than the most recent drills, it was noted that the numbers of staff who participated in the June 2023 fire drill appeared higher than those indicated by a night-time evacuation plan. The concerns around fire evacuation in this bungalow prompted the Chief Inspector to seek further assurances in this in the days following inspection.

In response to these, it was indicated that a further drill had been conducted on 12

April 2024 with a five minute 46 seconds evacuation time indicated. While this time was lower than the two previous drills and did involve residents being in bed, it was notable that this drill only involved three of the four residents living in this bungalow. In submitting this response the provider indicated that further drills would be carried to seek to reduce the evacuation further and that evacuation plans would be updated.

Further information received following this inspection also indicated that 8% of staff working in this centre had not completed fire safety training.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Appropriate facilities were provided for medicines to be stored securely and a sample of medicine records reviewed indicated that medicines were being administered as prescribed. However, some improvement was needed around aspects of medicines management and related documentation. These included;

- Some discrepancies were found between prescription records and administration records. For example, some residents were no longer prescribed particular PRN medicines (medicines only taken as the need arises) but such PRN medicines continued to be listed on the residents' medicine administration sheets.
- While protocols were in place for some PRN medicines providing guidance on when they were to be used, PRN protocols were not in place certain PRN medicines.
- A PRN protocol for one medicine had not been updated to reflect a reduction in usage.
- The protocol for one PRN medicine did not match the dose to be administered as outlined in the resident's prescription records.
- One resident was written up receive one PRN medicines in two different routes but there was no guidance available on when to administer in either route.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans in place with a sample of these reviewed by inspectors. Such plans were subject to multidisciplinary review but it was noted that some periodic service reviews for one resident were not happening at the outlined frequency indicated. While the contents of the personal plans reviewed had been

recently updated and did provide some guidance in meeting residents' needs, it appeared that in some areas there was a reliance on staffing knowledge in meeting particular health needs rather than ensuring that such knowledge was reinforced by the presence of appropriate healthcare plans. As such some improvement was identified regarding the content of some healthcare plans in place including;

- There was variance in quality of some residents' healthcare plans with some more personalised than others.
- Some residents had healthcare plans in place than remained open but were not active. For example, one resident had a healthcare plan in place around a tooth ache from 2021.
- One resident had a care plan around diabetes even though it was indicated that the resident did not have diabetes.
- One resident received percutaneous endoscopic gastrostomy (PEG) feeding but their care plan in place around this did not include guidance on cleaning the PEG site.

As part of the personal planning process, residents were supported to participate in a POMs process to identify goals for them to achieve. Some improvement was identified in this area also including;

- Some goals identified did not set out time frame for when goals were to be achieved.
- One resident had been living in the centre since May 2022 but had only recently completed a POMs process.
- Goals identified for residents were very similar with some goals being continuing things that residents were already doing such as attending their day services and participating in music therapy.

Judgment: Not compliant

Regulation 6: Health care

Residents did have healthcare plans in place but some areas for improvement were identified in these which are highlighted under Regulation 5 individualised assessment and personal plan. Residents were supported to avail of a general practitioner (GP) with a GP seen to visit one bungalow during the inspection to review a resident. Records provided indicated that there was monitoring of residents' health needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was updated guidance in place related to positive behaviour support and staff spoken with demonstrated a good awareness of this. Records provided indicated that a particular restrictive intervention had been discontinued since October 2023. However, a protocol relating to the use of this restrictive intervention from May 2023 still remained in the resident's personal plan. While it was indicated to the inspectors that this remained in case this restrictive intervention was ever need again, the protocol had not been updated to reflect that the restrictive intervention had been formally discontinued.

Judgment: Substantially compliant

Regulation 8: Protection

All staff had completed safeguarding training and no safeguarding concerns were identified during the inspection. Information around contacting the provider's designated officer (person who reviews safeguarding concerns) was on display in the buildings visited with staff spoken with aware of this. Residents had intimate personal care plans in place outlining supports they needed in this area.

Judgment: Compliant

Regulation 9: Residents' rights

While staff on the day of inspection were observed and overheard to interact with residents in a respectful manner, some improvement was required to ensure that residents' rights were fully promoted. These included;

- It was identified that some residents were receiving checks in their bedrooms at night which had the potential to impact residents' privacy. The rationale for such checks was not always documented.
- For one resident it was indicated that they were to receive such checks due to possible seizures. However, the same resident had a bed senor already in place related to this so it was unclear why the night checks were also needed.
- A delivery person was seen to enter one bungalow without knocking on the front door or ringing the doorbell first.
- Documentation reviewed indicated that decisions around aspects of the support residents received were discussed with residents' families but not with the residents.
- During the inspection it was noted that one resident had fitted furniture in place that had had been paid for with the resident's funds whereas similar furniture for other residents had been paid for by the provider. No evidence of consultation with this resident was seen during the inspection around this.

	Following the inspection it was indicated that there was no written evidence of engagement with the resident regarding the purchasing of the furniture however relevant stakeholders were aware of the purchase. It was also indicated that while the furniture was fitted for a space in the resident's bedroom, it was transferable.
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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for No 2 Cordyline OSV-0004594

Inspection ID: MON-0034339

Date of inspection: 08/04/2024

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The Provider will ensure that the role of each staff member in delivering person-centred, effective, safe care and support to the residents is supported and that the s there are suitably qualified, competent and experienced staff rostered as set out in the Statement of Purpose. Recruitment, supervision, training and performance appraisal systems will continue to promote a rights based team approach to providing supports. All efforts are made to maintain the staff numbers and skill mix at a level appropriate to the number of residents and their assessed needs and in line with the Statement of Purpose and in particular:-

• The Provider will support the Person in Charge, in consultation with the human resources department, to continue to actively recruit for the vacant posts.
• There are ongoing recruitment campaigns in place for team leaders, nurses, social care workers and support workers (continuous campaigns in 2023 and 2024).

• Since the inspection four of the five houses that make up this designated centre have a team leader in place. We continue to recruit the fifth team leader. We hope to have the remaining team leader in place by the 30/09/2024.

• The Provider has recruited a Residential Services Manager to support the Area Manager to manage the designated centre. This Manager commenced on 29/04/24.

• Since the previous inspection, a new post has been created, 'Regional Roster Coordinator' and this post provides access to relief staff where normal relief staff are unavailable. The Person in Charge had access to these additional relief staff prior to, during the inspection and continues to have access to same.

• Where there are staffing shortages on a given day due to unplanned sickness of a team member, these will be covered where possible from the local relief panel or failing that with agency staff where available. In these cases, our clinical nurse management team

prioritise safe care and make informed risk based decisions about how best to allocate staff resources across the houses that are part of this designated centre.

• If it is the case that a resident's activity needs to be deferred due to staffing shortages, the reason will be explained to the resident and rescheduled in consultation with the resident, as soon as possible. This will be detailed in their daily activities log book. The resident will also be offered the opportunity to make a complaint.

• Where staff shortages impact on the persons achieving their personal outcome goals, the house staff team meetings will discuss goals progress. This will provide staff with an opportunity to celebrate goal achievement but also identify barriers to achieving these goals and solutions discussed and elevated to PIC and Sector Manager where necessary for resolution.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Provider recognises the importance of training and development for staff and its impact on the service provided to residents.

All staff are trained to take a person-centred approach to care. All staff are supported to receive training on various issues including on human rights and a rights-based approach to providing safe services and supports to residents. Induction and ongoing training programmes are planned and a training matrix maintained in the Centre.

To address gaps in current trainings due the following actions have been identified:-

• The Person in Charge will ensure a quarterly review of the training matrix in each house is carried out to ensure gaps in both online and classroom-based training are identified in a timely manner. The personal assistant to the Person in Charge (Area Manager) continuously reviews the schedule of training available and assists staff to book onto classroom-based training in conjunction with their Team Leaders and the Person in Charge.

• The Person in Charge will continue to engage with the training department. A training needs analysis is completed annually for each house and if this analysis identifies further training needs then this will be highlighted to the training department by the Person in Charge and planned for.

• The Person in Charge will reinforce the importance of staff training at team meetings scheduled to be held every six weeks. Staff have been and will continue to be supported to access mandatory online training. The Person in Charge will aim for full compliance in

our core teams and core relief staff by 30/07/24. The release of staff for classroom based mandatory training has been and continues to be prioritised. Full compliance of all staff to have in-date training in the required areas will be scheduled for completion by 30/09/2024 (this time line is necessary to allow for some training to be sourced externally etc).

• The Person in Charge will ensure that staff are appropriately supervised and that the supervision schedules for 2024 is finalised. The supervision of frontline staff is assigned to the line managers of each staff member. The night coordinators are currently assisting the Person in Charge in the carrying out of front line supervision in houses that do not have an appointed team leader. The Person in Charge is responsible for ensuring that supervisions take place in accordance with the schedule. The schedule will be further reviewed by the PIC bi-annually to ensure supervision has taken place for all staff in previous six months. The first review is to take place on 18/07/24.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider has a system of internal compliance checks in place to ensure systems and processes in the Centre support informed and timely decision making to support the residents to achieve best possible outcomes.

The management systems are designed to ensure that effective governance and management, consistency of service in line with the statement of purpose and the effective and efficient deployment of resources.
Systems are in place for continuous oversight and management of the Centre
• workforce planning and contingency planning as set out under Regulation 15
• Internal audit of systems in the Centre undertaken by the Person in Charge
• Provider unannounced visits at lease every six month
• Annual review of the quality & safety of care and support at the Centre
• Ensuring actions arising from internal audits and inspections by the Authority are acted upon on a timely basis

The Provider will ensure that
• Staffing shortages are addressed with the Human Resources Department, PPIM and PIC
• Staff are supported to attend training and supervision sessions on on-going basis

• The Provider will appoint the Residential Services Manager as a Person in Charge in June 2024. This post-holder will report to the Area Manager. This will result in an additional manager available to persons supported, their families and the staff team of this designated centre.

• There is a clearly defined management structure at the centre. In June 2024, each team leader will be provided with a set of responsibilities that outline their day-to-day line management of the centre. The night coordinators will also support the PIC and the team leaders in their discharge of their duties.

• The Person in Charge will carry out the below audits:

1. PIC audit for the designated centre
2. Self-Assessment Tool – Infection Control
3. HIQA Quarterly Restrictive Practice – Self Assessment Questionnaire
4. Annual Safeguarding Audit
5. Annual Environmental Audit
6. Annual Fire Safety Audit Provider
7. Quarterly Medication Audit

• The Person in Charge and Sector Manager compiled a comprehensive annual review of the centre in February 2024. This review has a set of actions that will be reviewed monthly by the Area Manager. This review had already included reference to consultation with persons supported and their representatives. This review has been shared with staff teams April 2024. The review will be shared with the residents during monthly residents meetings in 2024.

• The Registered Provider carried out two unannounced inspections at this centre in 2023. They will continue to carry out these inspections in 2024. At time of this compliance plan all of the five houses have had their inspection carried out. An action plan has been created by the Person in Charge for each set of findings. The Person in Charge is tasked with oversight of these plans and reporting progress to the PPIM. The Provider will ensure six monthly unannounced visits continue to be completed in line with regulations and actions arising therefrom are addressed on a timely basis

• The Provider will support the recommendations of the accommodation review to support physical adaptations as outlined under Regulation 17 Premises and under Regulation 11 Visits

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The Provider has developed a new Residential Service Agreement and an Easi Read version for issue to all residents and/or their representatives. This will be issued to all residents in the Centre by 12 June 2024 with a targeted return date of 30 June 2024. Residents and representatives who do not wish to sign the Agreement are asked to communicate the reason why they do not wish to sign the agreement. Where

residents/representatives indicate reasons for non-agreement with the terms in the agreement the Provider will follow up to seek to resolve the matter by 31/08/2024.

For all new admissions to the Centre, the provider will ensure that the Residential Agreement issues as part of the Offer of Admission Welcome Pack.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
At the time of this inspection, the complaints/concerns/compliments log had been reviewed quarterly by the Person In Charge in line with organisational return to the HSE.

The complaints/concerns/compliments log will be reviewed monthly by the Person in Charge ensuring all complaints and concerns have been managed appropriately and the resolution of any complaint by a resident or a family member is clearly recorded. It will also set out whether or not the complainant is satisfied, or otherwise with the outcome.

Entries into the complaints/concerns/compliments log will be reviewed/discussed by Team Leaders and the Person in Charge at their six weekly meetings.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
The Provider promotes the importance to residents to have regular visitors and encourages families and friends to maintain social interaction and residents to expand their personal relationships with their natural support networks and community links.

Visitors are welcome in the service and encouraged to participate in the resident's life, if the resident so wishes. The residents can currently receive visitors in the communal sitting room in their home or in a nearby facility on campus "The Cottage" (details of which are set out in the statement of purpose).

The provider monitors how visiting arrangements are facilitated. Evaluation of the effectiveness of the visiting arrangements and if there are suitable communal facilities and private areas available for residents to receive visitors. With new admissions and changing needs it has been identified that more communal space to receive visitors in residents homes should be planned for and the following actions identified:-

• In conjunction with the Provider and Facilities Manager, the Person in Charge will review each home within the centre in order to develop plans for expanding communal space where possible. This review will consider the changing needs of the residents within each home, current vacancies in the houses and the possible re-organisation of existing communal spaces. The review will be completed by the 31/07/2024. Following this review a written time-lined action plan will be set out. This may include amendments to floor plans and if so amended plans will be submitted to the Authority in the form of an application to vary. The Provider aims to have the actions implemented on a phased basis from August 2024 to 31/10/2024
• The Provider has arranged for another facility for visiting to be made available from June 2024. This is in close proximity to all of the five houses. This space is called the 'Butterfly' room is a bright, spacious, comfortable, private space that is wheelchair accessible. The building also has toilet facilities. This building is open for all residents to use with immediate effect. An updated laminated poster is displayed in each house for all residents and their visitors informing them of same.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider continues to monitor the appropriateness of the premises to meet the assessed needs of residents. Some areas have been reconfigured in 2023 to meet changing needs and others are planned as follows:-

• In June 2024, works are due to commence in one home, which will include widening of some doors within the home and refurbishment of one shower/toilet facility to a wet room. These works are estimated to take three weeks. These renovations will benefit all residents living within this home. There will be no change to the footprint of the house as the measurement of the relevant walls remains unchanged and door frames are being widened.

• A multidisciplinary assessment from November 2022 outlined that one resident would benefit from a single occupancy living arrangement. This assessment was completed for a resident with complex needs in the first six months of their admission. As the person is now settled into their residential placement and their needs are more fully understood, this recommendation is now examined further and will be completed by the 30 August 2024. The recommendations arising from this review will be considered in two ways; where possible recommendations will be made to their current environment and secondly recommendations will be incorporated into the Provider's decongregation plan.

• It has been recommended that for a second resident adaptations are to be made to their current environment by way of a functional space for the staff team to situate themselves when the person indicates they want time alone. The functional space will be in the form of a modular staff office. This is due to be ordered by the 14 June 2024 and estimated to be in place 20-24 weeks following the date of the order (allowing for order,

assembly and electric fittings). 30 November 2024.

• The Provider in conjunction with the Person in Charge will continue to review all premises in line with changing needs of residents, opportunities that arises with existing vacancies and proposed decongregation plans. This will ensure that all residents are supported in an environment that meets their needs and is both safe and homely. An updated outline de-congregation plan will be set out for joint feasibility review with the HSE in October 2024.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge will ensure that Team Leaders are reviewing their risk register and updating the register appropriately.
• The team leaders and Person in Charge will ensure that individual risk assessments are reviewed according to risk rating guidance and in line with changes to the resident's presentation or person overseeing the risk.

With regards to fire and risk management, where required the Person in Charge will review their live centre risk register to include specific reference to specific fire matters. This will be carried out in June 2024.
• The Person in Charge will ensure that they will now receive a copy of all fire drill records once a drill is completed. They will review same and ensure any corrective actions outlined are planned for and take place. This is in place with immediate effect following the inspection.
• The Provider, through the Person in Charge will ensure a review of personal emergency evacuation plans are completed when a resident presents with a change in their presentation during evacuation. This will result in an updating of the personal emergency evacuation plan (PEEP).

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Person in Charge will ensure that they receive a copy of all fire drill records once a drill is completed. They will review same and ensure any corrective actions outlined are carried out. (continuous and put in place immediately following the inspection)
• The Provider, through the Person in Charge will ensure a review of each person's

personal emergency evacuation plan (PEEP) is completed when a resident presents with a change in their presentation during an evacuation. (continuous and immediate following the inspection)
• The Person in Charge will determine if there is an additional need for any other risks associated with fire (not already included in each house risk register) to be included. 30/06/2024.
• The Person in Charge has and continues to have up to date information on fire training records of all staff working within the centre. The Person in Charge had identified a number of gaps during the inspection and these are due to be closed out by the 30 June 2024.
• Following this inspection, the provider in their provider assurance report carried out a programme of five fire drills one house and these drills consisted of both a mixture of day and night drills. At the end of the series of fire drills, the evacuation time during day and night time was shown to be three minutes or under. The Person in Charge is running an additional night-time fire drill that will reflect only the number of staff due to attend as per the night time procedure (9 June 2024), this is necessary due to excess staff presented and responded to the latest night-time drill.

• The Person in Charge to ensure that as permanent and relief staff are inducted into each house, their induction includes reference to fire evacuation procedures for each resident. This will be evidenced in the induction form completed and signed by the person giving the induction and the person receiving the induction.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Person in Charge will ensure all staff involved with the management of medications have access to the most up to date BOC Medication Management Policy which provides clear guidelines in all areas of Medication Management. Completed May 2024.

• The Person in Charge will ensure that medication audits are completed in a robust manner each quarter as outlined by BOC Person in Charge audit schedule. The Person in Charge will be informed of any actions required to improve systems in line with the Medication Management Policy. (immediate since the inspection)

• The Person in Charge will ensure engagement with pharmacy supplier to ensure accuracy between prescription records and administration records ensuring that these are accurate and up to date.

• All PRN medications prescribed will have a corresponding PRN protocol which will give clear guidance to the administrator. (31/07/2024)

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 Registered Provider has developed a new Personal Plan Template that is being rolled out across the service. All residents within this centre will have this new template in place by 30/09/24.

In regard to personal outcome measures:
• Following on from this inspection the Person in Charge and Residential Services Manager will review all residents POMs plan. This is to ensure all residents have SMART goals identified in their plan. This will be carried out as an exercise on the existing Person in Charge audit. To be completed by 30/07/24.

• Where goals are found to be repetitive, not specific, measurable, actionable, measurable and timely feedback will be provided to each team leader and key worker in August 2024. Team leaders will be asked to carry out a repeat POMS meeting with the person supported and the family.

• The Person in Charge will ensure that the progress of these goals are discussed at house team meetings. This will provide staff with an avenue to identify barriers to achieving POMs goals and ensure same escalated to the area manager.

• The Person in Charge will ensure that key workers are supported to attend the relevant training for those on the team idenfied in these roles. All relevant staff to be schedule for training by the 30.06.2024.

• The Person in Charge in conjunction with the Team Leaders will support keyworkers to have access to the POMs facilitator within the BOC to support them in determining specific, measurable, actionable, realistic and timely goals with residents.

In regard to healthcare management plans:

• The Person in Charge in conjunction with the relevant team leader has reviewed and updated the healthcare management plan for one resident receiving percutaneous endoscopic gastrostomy (PEG) feeding and this now includes guidance on cleaning the PEG site.

• The team leaders are responsible for the development and review of health care plans that contain up to date information. They are also responsible for ensuring that information that is not required to be kept in the file is archived responsibly. In this

regard, the person in charge has created a programme of review for each residents healthcare management plans to be reviewed, specifically with reference to the findings of this inspection. This programme of review will commence 05/06/24 and will conclude 10/07/24. Following this, all healthcare management plans will only reference the current needs of each resident.

The Person in Charge has developed a schedule of Periodic Service Review meetings for one resident of their behaviour support plan recommendations. Completed

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge has ensured that a protocol on the use of restrictive practices is now clearly noted as inactive and archived. Completed

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Provider continues to ensure that the culture of the service is one that ensures the rights of residents are promoted and protected and that the approach promotes empowerment and participation of residents in their own care and support plans.

The Provider will ensure that:

• Person in Charge will assess for each resident the level of support they require at night-time while they sleeping to ensure that when the night awake staff are checking them they are carrying out these checks in accordance with their needs. 31 July 2024.

• The Person in Charge has ensured there are signs on all of the front doors for visitors to ring the doorbell and wait until resident or staff comes to greet the visitor. Completed May 2024.

• Residents have the right to lock their front door to ensure people do not enter uninvited. Furthermore, there is a sign on each door prompting the staff to lock the front doors from the inside using a thumb turn lock where this is appropriate. Residents have therefore the freedom to open their door using the thumb turn lock to greet visitors upon

their arrival. Completed May 2024

• The Person in Charge will ensure that the rights of the residents are upheld. The resident will be involved in all decision making pertinent to them. Their will and preference will be evidenced in their personal plan in and in the meeting notes of their house meetings. (continuous)

• The Person in Charge will ensure that all decisions that are required to be made by persons we support will be made by them and it will be assumed that they have the capacity to do same. Where concerns are raised regarding capacity, the Residential Services Manager and Area Manager will support each person using the Assisted Decision Making framework. (continuous)

• The Person in Charge will ensure that in accordance with our policy on personal possessions, it will be evidenced clearly that any decision making regarding purchases that a person may like to make follows the established procedure set out in the 'Local Procedure for the management of monies that belong to people supported by the Services'. The Residential Services Manager will re-issue the team leaders this policy by the 30/06/2024.

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 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident's room, is available to a resident in which to receive a visitor if required.	Substantially Compliant	Yellow	31/10/2024
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	30/09/2024
Regulation 15(2)	The registered provider shall	Substantially Compliant	Yellow	30/09/2024

	ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/09/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2024
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/11/2024
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with	Substantially Compliant	Yellow	30/09/2024

	reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2024
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	31/08/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	31/07/2024

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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 and bringing them to safe locations.	Not Compliant	Orange	09/06/2024
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	31/07/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal	Substantially Compliant	Yellow	31/07/2024

	and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	30/06/2024
Regulation 05(4)(c)	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 is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or	Not Compliant	Orange	31/07/2024

	her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/06/2024
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	30/06/2024
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	30/09/2024
Regulation 07(4)	The registered provider shall ensure that, where	Substantially Compliant	Yellow	31/05/2024

	restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/06/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy 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.	Not Compliant	Orange	30/07/2024