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:	Dun Aoibhinn Services Cahir
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	15 February 2024
Centre ID:	OSV-0005066
Fieldwork ID:	MON-0041591

About the designated centre

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

Dun Aoibhinn Services Cahir is a designated centre operated by Brothers of Charity Services Ireland CLG. The designated centre provides a community residential service for up to eight adults with a disability. The designated centre consists of two houses located within a close proximity to each other in a town in County Tipperary. The first house is a two storey house which comprised of a kitchen/dining room, living room, four individual bedrooms (two of which were en-suite), sensory room office and staff sleepover room. The second house is also a two storey house which comprised of a living room, kitchen/dining room, office, four individual bedrooms (one of which was en-suite) and a staff sleep over room. There are gardens to the rear of both houses for the residents to avail of as they please. The centre is staffed by the person in charge, staff nurse, social care workers and care assistants. The staff team are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 15 February 2024	09:20hrs to 18:20hrs	Conan O'Hara	Lead
Thursday 15 February 2024	09:20hrs to 18:20hrs	Miranda Tully	Support

What residents told us and what inspectors observed

This was an unannounced risk-based inspection carried out by two inspectors over one day. The purpose of this inspection was to determine progression levels by the registered provider to come into compliance with regulations, previously identified as requiring improvement during inspections completed in November 2022 and August 2023.

Over the course of the inspection, the inspectors visited both homes of the designated centre. The inspectors had the opportunity to meet with seven of the eight residents and seven staff members who were on duty. Overall, the inspectors found that the provider had not made sufficient levels of progress to move this centre into compliance and this was impacting on the quality of care delivered to residents.

Improvements remained required in resident compatibility, staffing arrangements, governance and management, notification of incidents, safeguarding, positive behaviour support, fire safety and resident's rights.

On arrival to the first house in the morning, the inspectors met with three of the four residents. One resident was attending day services and staying with relatives in line with their routine and personal plan. The inspectors observed the three residents were being supported by five staff members in line with their assessed needs.

The inspectors met with the three residents in the kitchen and sitting room. One resident was watching TV in the kitchen while another resident was preparing for their day. The third resident was observed in the sitting room. Inspectors observed the resident being directed to return to the sitting room after entering the kitchen area. Later inspectors were informed that this resident was encouraged to engage in individual activities and would spend minimal time in the house so as to avoid contact with the other residents. The inspectors observed the staff team organising to collect a vehicle from the second house in order to support one resident to access the community to go swimming. The inspectors were informed that due to recent issues with the house's two vehicles that this was a temporary measure. Later in the morning, two residents, were supported to access the community.

However, the inspectors did observe one resident spending a large portion of their day in the kitchen watching TV. The inspectors were informed that the resident required a wheelchair accessible vehicle to access the community and due to the issues with the service's transport, they did not have access to a suitable vehicle for the last two weeks. The provider noted following the inspection that other vehicles were available upon request.

The inspectors completed a walk around of this home accompanied by the person in charge. As noted, the designated centre comprised of four individual resident

bedrooms (two of which were en-suite), staff bedroom, office, shared bathroom, sensory room, sitting room, utility room and an open plan living, dining and kitchen area. In general, the house was observed to be decorated in a homely manner with residents' personal possessions and photographs on display throughout the centre. However, there were areas of chipped and damaged paint observed which required review. This was also identified at the time of the last inspection. The inspectors also observed gravel surrounding the centre which continued to present as a hazard and accessibility issues for one resident with limited mobility. This had been identified on previous inspections and internally by the provider. The inspectors were informed that the provider is continuing to progress a long-term plan to address same.

In the afternoon, the inspectors visited the second house which was home to four residents. The inspectors met the four residents as they returned from their day service. The residents appeared happy to be home and spoke with the inspectors about their day and sports they enjoyed.

The previous inspection, identified that the staffing levels in this house required significant improvement as the four residents were supported by a lone staff member day and night. This meant that the residents had limited opportunity for activities in the evening and weekends due to the identified supervision and safeguarding needs of the residents. Following the inspection, the provider had introduced a second staff member to support the residents in the afternoon and weekends. The inspectors observed that the four residents were supported by two staff on the day of the inspection. The inspectors were informed that the two staff members were relief staff - the afternoon shift was being completed by a regular relief staff member and the sleepover shift completed by a new relief staff member who had not worked in the house previously.

The inspectors completed a walk around of this house accompanied by the person in charge. The designated centre comprises of four individual resident bedrooms (two of which are en-suite), staff bedroom, office, two shared bathrooms, sitting room, utility room, and kitchen/dining area. The house was observed to be decorated in a homely manner with residents' personal possessions and photographs throughout the centre. The previous inspection found that some areas of the premises required maintenance including internal and external painting, replacement flooring throughout the premises and the need to upgrade/replace some windows and patio doors. It was evident that this was in the process of being addressed. For example, the inspectors observed that internal painting had been completed and new flooring and windows had been installed in the house.

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

Capacity and capability

Overall, this inspection found that the registered provider had failed to make sufficient levels of progress to move this centre into compliance and this was impacting on the quality of care delivered to residents.

There was a governance structure in place and the centre was managed by a full-time person in charge. However, improvements were required in the effectiveness of the governance and management systems to address the areas previously identified for improvement. This is reflected in high levels of non-compliance with the regulations as outlined in the report including staffing, training and development, protection, positive behaviour support, fire safety and residents rights.

While, quality assurance audits were taking place to assess and monitor the service these were ineffective. For example, the latest six-monthly audit carried out in November 2023, did not cover both houses of the centre. The absence in effective audit, oversight and management was not driving the improvements that were required.

The inspectors reviewed the staffing arrangements in both houses and found that these required further review. For example, while the staffing arrangements had been enhanced in both houses following the findings of previous inspections, it was not demonstrable that it was sufficient at all times to meeting the assessed needs of residents. For example, two-to-one staffing was not available for one resident in line with their documented assessed need after 16:00 during the week and on weekends. In addition, improvement was required in the notification of incidents.

Regulation 15: Staffing

The previous inspections found that the staffing arrangements required improvement. While there had been increased staffing in both houses in response to the previous inspections, the inspectors found that the provider could not demonstrate that the current staffing arrangements were sufficient to meet the needs of all residents at all times.

For example, in house one, one resident was assessed as requiring two-to-one support for significant parts of the day to assist with activities of daily living including mobilising and personal care. While, there was evidence of enhanced staffing levels in place for 36 hours a week, the resident was not staffed two-to-one after 16:00 during weekdays or at weekends.

In addition, in house two, safeguarding and supervision measures identified the requirement for ongoing supervision and support for one resident. While there was evidence of increased staffing levels at the evening and weekends in response to the previous inspection, the four residents were supported by a lone member of staff from 21:00 in the evening until the following morning.

Overall, it was not demonstrable that the staffing arrangements ensured a

consistent level of care and support was provided to residents in line with their assessed needs.

Judgment: Not compliant

Regulation 16: Training and staff development

The systems in place for training and development required improvement to ensure that all of the staff team had the knowledge and skills to meet the needs of the residents. For example, a number of staff required training in de-escalation and intervention techniques for challenging behaviour and manual handling. This was identified as key training for the staff team to complete in order to support a number of residents with their assessed needs in one of the houses. While this had been self-identified by the provider, it remained outstanding at the time of the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, improvement was required in the governance and management systems in place to ensure the delivery of quality care and support to residents.

The inspectors found that improvement was required in the effective management of the service to ensure the that the service provided is appropriate to residents' needs and to move this centre into compliance.

For example:

- Governance and management in this centre has not been found compliant in the previous three inspections of this centre. The person in charge was on a planned absence at the time of inspection and deputising arrangements were put in place by the provider. These arrangements were deemed insufficient, as were the levels of managerial support, monitoring and oversight of this centre.
- Staffing arrangements were found to be inadequate to meet all of the residents' assessed needs on the previous two inspections. On this inspection, it was not demonstrable that the increased staffing arrangements were sufficient to meet the needs of all residents at all times as outlined under Regulation 15: Staffing.
- Gaps in training in key areas such as de-escalation and intervention techniques were identified through internal audits and staff team meetings. This issue remained ongoing at the time of the inspection.

- In December 2023, the provider self-identified that a number of fire doors did not close fully which negated the integrity of the fire doors/fire containment measures. This remained a concern on this inspection.
- The arrangements in place to manage the service's vehicles negatively impacted on one resident who required a wheelchair accessible vehicle.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed a sample of incidents and accidents occurring in the centre. For the most part, incidents and accidents were notified to the Office of the Chief Inspector as required. However, one incident of a potential safeguarding concern was not notified as appropriate.

Judgment: Not compliant

Quality and safety

Overall, the systems in place did not ensure a quality care and support was provided to residents at all times.

This inspection found that significant improvement was required in fire safety, protection, positive behaviour support and residents rights. In addition, there remained some improvements required in the premises.

The inspectors reviewed a sample of residents' personal files which comprised of a comprehensive assessment of residents' personal, social and health needs. However, improvement was required to ensure the plans guided the staff team. For example, one resident plans noted not to wake them up to administer morning medication and to administer it later in the morning. On review of daily notes, it recorded that the resident was woken up several times in order to administer the medication.

The systems in place for positive behaviour support required improvement. For example, one behaviour support plan reviewed was not up-to-date and reflective of the current support arrangements in place. Restrictive practices were in use in the centre and the inspectors found that improvements were required in the timely review of same.

In addition, improvement was required in the systems in place for fire safety. For

example, the inspectors found that improvement was required in the guidance to support residents to evacuate in the event of a fire and in the completion of night-time fire drills. Similar findings had been made on previous inspections.

Regulation 17: Premises

Overall, the designated centre was designed and laid out to meet the needs of the residents. The inspectors found that the two houses were decorated in a homely manner.

The previous inspection found that improvements were required in both houses including areas of paint, flooring and windows. The inspectors did observe work completed by the provider including internal painting and new windows and flooring installed in house two. However, some areas for improvement in house one remained including the gravel surrounding the premises which caused accessibility issues for one resident and areas of internal painting/decoration were still required. These issues have been identified in previous inspections and remain ongoing.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The fire safety systems in place required improvement. For example, the arrangements in place for the containment of fire required improvement. The inspectors observed that a number of fire doors did not close fully in house two. This negated the purpose and function of the fire doors. From a review of records, the provider had self-identified that a number of fire doors were not closing fully in December 2023. This issue was ongoing at the time of inspection.

In addition, a night-time drill or minimum staffing drills to demonstrate that all persons would be safely evacuated in the event of a fire had not been completed within the last year. This was previously found as an area for improvement on the November 2022 inspection.

Each resident had a personal evacuation plan in place. However, the personal evacuation plans required review to ensure the staff team were appropriately guided to support residents to evacuate in the event of a fire. This had also been identified as an area for improvement at the November 2022 inspection.

The inspectors also found that the fire evacuation procedures did not include the assistive equipment required for one person to evacuate. The procedures also indicated residents should evacuate to a bus or the gate if the bus unavailable, both options were inaccessible on the day of inspection.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Overall, the systems in place to support residents manage their behaviours required improvement.

For example, positive behaviour support guidelines were in place, as required. However, one positive behaviour support plan reviewed was not up-to-date and accurately guide the staff team in supporting one resident manage their behaviours. The inspectors spoke with seven staff members and found that in some instances the knowledge of the staff team regarding the resident's behaviour, supports and interventions required improvement.

There were a number of restrictive practices in use in the designated centre. The inspectors reviewed a sample of documentation and found that the restrictive practices had not been reviewed in a timely manner by the provider's Human Rights Committee. In some instances, it was not demonstrable that restrictive practices were used for the least amount of time necessary. For example, the use of a transport harness on a bus for long periods of time for one resident. The inspectors were informed that the information had been submitted to the Human Rights Committee for review. The inspectors were also told that a restrictive practice audit had been recently completed and the report with recommendations was being drafted at the time of the inspection.

Judgment: Not compliant

Regulation 8: Protection

The systems to keep residents safe required improvement.

For example, some staff spoken with did not demonstrate an appropriate knowledge of safeguarding and supervision plans in place in one house. Also, as noted under Regulation 15: Staffing, it was not demonstrable that the staffing arrangements were adequate to implement the safeguarding and supervision guidelines that were outlined as necessary.

In addition, one concern regarding resident's finances was identified. While, there was some evidence of local follow up, it had not been identified, managed or investigated as a safeguarding concern nor had the matter being reported and managed in line with the provider's safeguarding policy and the national safeguarding policy. For example, some measures were only being taken in the days following this inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

The previous inspection found poor practices in relation to residents' rights. While, there had been some improvements with staffing levels this remained an area for improvement.

The inspectors found that the residents' choice and control within their home was limited at times. For example, there was no accessible transport vehicle available to one resident to support them to access the community. While the provider noted that this was a temporary issue, it had a significant negative impact on the choice and control to this resident.

The inspectors were also informed that in the first house, when the four residents were present for the weekend, that there was practice in place for two of the residents to separately spend significant portions of the day out of the house in order to manage possible negative peer-to-peer interactions. The inspectors observed the two residents spent significant portions of the day outside of the house from a review of daily notes and were informed that this could be up to nine hours. In addition, it was noted that staff members coordinated meal times during the weekend so the residents did not meet each other. It was not evident that the provider had considered the long-term suitability of such arrangements and the overall compatibility of the resident group.

In addition, the provider had completed individual rights assessments for each resident. From a review of a sample of these assessments, there was areas for improvement to accurately reflect the practice in the centre. For example, one assessment found that a resident could chose to access the community when they wanted with the support of staff. However, the resident required two-to-one staffing to mobilise and it was not demonstrable that this staffing support was in place at the weekends.

There was one daily practice in place to manage a historical safeguarding concern which impacted on one resident's privacy and dignity. It was not evident that this practice had been appropriately reviewed to reduce or remove this practice.

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 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Dun Aoibhinn Services Cahir OSV-0005066

Inspection ID: MON-0041591

Date of inspection: 15/02/2024

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: 1. All resident's individual behavioural support plans and safeguarding plans will be reviewed to ensure that the staffing levels are appropriate to meet the needs of all residents. 2. On completion should there be any identified gaps in staffing resources these will be notified to senior management through the completion of DSMAT. 3. The PIC will review lone working protocol in the context of the risk assessments that are in place in the designated centre.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The training matrix for all staff within the designated centre will be reviewed and the PIC will ensure that any outstanding mandatory training is completed and the matrix updated to reflect this. 2. PIC will ensure all staff have completed Safety Intervention Foundation training (formally MAPA) as required.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Quality improvement plan to be developed for the centre to ensure effective monitoring and oversight from a provider level. 2. Services Manager to attend team meetings on a regular scheduled basis to review actions on quality improvement plan and to provide direct monitoring, oversight and support. 3. Regional Services Manager to visit the designated centre at minimum once a month to provide managerial support and guidance and review quality improvement plan.	

4. The process for accessing an alternative wheelchair vehicle should one be required will be documented and all staff will be informed of the process. 5. All identified works required for fire doors have been prioritised for completion by Friday 15/03/2024. 6. PIC will ensure any outstanding mandatory training will be completed and the training matrix for all staff within the designated centre will be reviewed and updated to reflect this. 7. PIC will ensure all staff have completed Safety Intervention Foundation training (formally MAPA) as required. 8. The PIC will ensure that staff practice is guided by the residents personal plans

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: 1. All incidents to be notified as per policy. 2. Safeguarding is an agenda item at all team meetings.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: 1 The gravel area around exterior of premises has now been repaired. 2. Modifications to resident's wheelchair have been made to assist with ease of movement. 3. Areas identified as requiring painting will be completed by 30/04/2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. All required works around fire doors have been identified and reviewed and by installer and have been prioritised for completion by Friday 15/03/2024. 2. Deep sleep fire drill has been completed and a schedule of further dates have been outlined going forward which the PIC will oversee. 3. All Peeps have been reviewed and updated to ensure staff are appropriately guided to support residents to evacuate in the event of a fire. All staff to inform themselves of PEEPs and sign a sheet once completed indicating that they have read and understood them. 4. Fire Evacuation Plans and PEEPs now include information in relation to the assistive equipment required for one person to evacuate.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1. MDT meeting held and the identified positive behavior support plan updated. 2. All IBSP to be discussed at team meetings, staff to sign that they have read and understood these and updated as required. 3. Full review of restrictive practices will take place in conjunction with the Human Rights Committee and CQL quality team. 4. Actions identified through the restrictive practice audit held in February 2024 by an external consultant will be implemented.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: 1. All safeguarding protocols to be discussed with all staff at every forum 2. The provider will ensure that staffing levels will correspond with the assessed need of all residents in the centre. 3. All incidents will be notified as per policy going forward.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: 1. The process for accessing an alternative wheelchair vehicle, should one be required, will be documented and all staff will be informed of the process. 2. MDT and senior management to conduct a review of incidents and safeguarding documents to establish if there is a pattern of concern in regard to compatibility or negative peer to peer interactions. 3. Review of all resident's individual behavioural support plans and safeguarding plans ensuring the appropriate staffing levels meet the needs of all residents. 4. On completion should there be any identified gaps in staffing resources these will be notified to senior management through the completion of DSMAT. 5. The provider will ensure that staffing levels will correspond with the assessed need of all residents in the centre. 6. A specific Human Rights Committee review has been requested to review a daily practice in place to manage a historic safeguarding concern. There is also an oversight of this practice through Management and Monitoring Committee.

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	30/09/2024
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.	Not Compliant	Orange	31/05/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/04/2024

	are of sound construction and kept in a good state of repair externally and internally.			
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.	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	31/08/2024
Regulation 23(2)(b)	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 maintain a copy of the report made under	Substantially Compliant	Yellow	31/08/2024

	subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2024
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	31/03/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/03/2024
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse	Not Compliant	Orange	31/03/2024

	incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	31/05/2024
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	31/05/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/05/2024
Regulation 08(2)	The registered provider shall	Not Compliant	Orange	30/04/2024

	protect residents from all forms of abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/06/2024