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:	Glebe Lodge
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	22 January 2024
Centre ID:	OSV-0001966
Fieldwork ID:	MON-0041793

About the designated centre

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

Glebe Lodge is operated from a large purpose built bungalow located on the outskirts of a small town. The centre has a maximum capacity of 11 and can provide full-time residential support for 10 residents and respite for one resident. The centre is intended to support residents with intellectual disabilities and those with high support needs related to aging of both genders over the age of 18. Support to residents is to be given by the person in charge, nursing staff, care assistants and catering staff. Within the centre there are eleven individual bedrooms for residents in addition to lounges, a kitchen-dining area, bathrooms and staff offices.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 22 January 2024	10:00hrs to 18:00hrs	Laura O'Sullivan	Lead
Tuesday 23 January 2024	10:00hrs to 18:00hrs	Lucia Power	Support

What residents told us and what inspectors observed

Glebe Lodge is a designated centre operated by the registered provider Kerry Parents and Friends Association. It is a large purpose-built bungalow located on the outskirts of a small town. The centre has a maximum capacity of 11 and can provide full-time residential support for 10 residents and respite for one resident. At the time of the inspection, one individual was availing of respite. They spoke to the inspector about their stay and told the inspector they were happy to spend their time there. They were relaxing during their stay and also told the inspector the staff were lovely and were looking after them well.

The inspectors had the opportunity to meet and observe with nine other residents over the course of the inspection. On arrival, one resident excitedly told the inspectors about their recent party that was held over the weekend to celebrate their birthday. Later in the day, this resident was in a communal living area doing their chosen activity of art. They chatted with the inspector about their favourite music and picked a CD with the inspector to listen to while in the room.

One resident smiled at the inspectors when they arrived as they waited in the doorway to attend their day service. Two residents in the centre were supported to attend a day service for a couple of days during the week. Other residents currently residing in the centre were supported to participate in activation within the centre. Staff supported residents to communicate with inspectors during the day.

On the day of the inspection, a number of residents did go on a spin to the local community. The number of residents who could access the local community or participate in a social outing was limited, as there was only one vehicle available and this was not accessible to all residents. Staff did tell the inspector that this was having an impact on the residents going to appointments and having access to community activities. It was also noted that not all staff could drive the centre vehicle, therefore, being dependent on having a driver on shift. The provider had a visual in place in a picture format of a bus and this system had a rotation order which meant that residents had to take turns to having access to the use of the vehicle.

Staff explained the activities which residents enjoyed participating in including massage, reflexology and music. It was observed that these activities and others were completed within the centre and not in the local and wider community. Within each resident's personal plan, it was not noted if this was the choice of the resident or if they had been consulted about thee therapies.

Interactions observed on the day were positive in nature and residents were observed to be comfortable in the presence of staff. Residents smiled when staff

interacted with them and turned their heads when they heard a staff approaching. Staff were very knowledgeable about the individual support of residents.

Inspectors had the opportunity to meet and speak with seven staff members on the day of the inspection. Staff spoke of improvements in the day-to-day operations of the centre since the previous inspection and spoke about the training they received and how it supported them in their roles. The staff also demonstrated a very good knowledge of the resident's needs and their care for the resident was very evident on the day of the inspection and in the manner they engaged with the residents.

Support was provided to staff through interactions with the person in charge. Staff spoken with also had an awareness of actions to be taken should a safeguarding concern arise including the importance of reporting any concern in a timely manner. The provider had implemented training in this area following the previous 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 the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection completed in Glebe Lodge, a designated centre operated by the registered provider Kerry Parents and Friends Association. An inspection had been completed within the centre previously on the 5th September 2023. This inspection evidenced a high level of non-compliance which resulted in the centre entering a period of regulatory escalation. This inspection was completed to ensure all actions set out by the provider to be completed had been adhered to and to monitor ongoing compliance with the regulations under the Hath Act 2007.

Since the previous inspection, a new person in charge has been appointed to the centre. They possessed the regulatory required skills, knowledge and experience to fulfil their role. They were full-time in their position and held governance over this centre only. They commenced in the role in October 2023 and completed a new number of duties to ensure compliance was achieved within the centre. This included the completion of staff supervision, team meetings and the introduction of an audit schedule.

The inspectors completed a review of the compliance plan response submitted by the provider following the previous inspection. It was noted that a large number of actions had been completed including staff training relevant to the assessed needs of the residents in such areas as positioning and transfers, family engagement and emotional support for residents as required. There was also evidence of increased

presence of members of the governance and management team.

However, there were a number of areas of concern evidenced on the day of the inspection that required additional assurances from the provider. In the days following the inspection a provider assurance request was issued to the provider to afford organisational-level assurances in the areas of residents' finances and records. This included the recording and administration of as-required (PRN) medications, the documentation of do not attempt resuscitation orders and receipt of medications.

The inspectors completed a review of documentation during the inspection. It was noted that practices within the centre were not corresponding to a number of these. For example, the use of residents' finances was not be completed in line with the Statement of Purpose and the signed contract of support. Where changes had been made to the fees payable by residents the contract of support had not been updated to reflect this.

While the registered provider had completed the regulatory required monitoring systems for the centre including the annual review of service provision and six monthly unannounced visits to the centre these tools had not been used to identify and address areas of non-compliance identified. Centre-specific audits had also not identified these with audits detailing high levels of compliance in such areas as medication management and personal possessions.

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had assured that the number, qualifications and skill mix of staff was appropriate to the assessed needs of residents. Nursing care was provided at all times. Where a vacancy was present this was covered with regular agency or relief staff to ensure the continuity of care was provided to residents.

The person in charge developed and maintained the actual and planned roster.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge was in the process of developing a supervision schedule for 2024. This was to afford time to build an awareness of the needs and concerns of staff since commencing their role in October 2023. In the event of the need for increased supervision a plan was implemented and actions recorded. New staff were supported through a probationary period.

Following from the previous HIQA inspection the provider had provided staff with training in such areas as challenging poor practice and report writing. On the day of the inspection it was difficult to ascertain if all staff had completed mandatory training as the records provided were not reflective of the all training completed.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider had not ensured all records were present and correct as required under Schedule 3 and Schedule 4 of the Health Act 2007. This included:

- The safe receipt, storage and administration of medicinal products;
- Any decision by a resident not to receive medical treatments including end of life decisions.
- Any fees to be charged including any extra amounts payable by residents for additional services. This was required to ensure consistency in the charges payable by all residents.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had ensured the allocation of a clear governance structure to the centre. Since the previous inspection there was evidence of increased interactions from members of the senior governance team.

While the registered provider had completed the regulatory required monitoring systems for the centre including the annual review of service provision and six monthly unannounced visits to the centre these tools had not been used to identify and address areas of non-compliance identified. Centre-specific audits had also not identified these with audits detailing high levels of compliance in such areas as

medication management and personal possessions.

The provider had not ensured oversight in relation to charges were made by the the resident had how these were been reviewed. For example, there were a number of entries in records where residents were paying for their physiotherapy and chiropody and no rationale for the requirement and duration of these services. It was also evidenced that residents had to pay for the support of staff at some community activities, including shopping locally for furniture, with no process or consultation with the resident evident.

In relation to this charge it was noted that two residents paid for a support service and it was documented that they were in the south of the county but on review, records stated they were actually in the North of the County. Therefore the provider did not ensure that what was outlined in the provider's statement of purpose was adhered to, therefore potentially breaching condition one of their registration.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had ensured the preparation in writing of a statement of purpose containing information as set out in Schedule 1. However, this required review to ensure all information was accurate and reflective of current practice within the centre and organisation.

Judgment: Substantially compliant

Quality and safety

As stated previously this was an unannounced inspection completed in Glebe Lodge. A number of non-compliances evidenced on the day of the inspection in the area of Quality and Safety will be addressed under Regulation 21. Improvements were also required to ensure residents' rights were promoted within the centre.

One area regulated under Regulation 21 is the area of medication. This refers to the practices observed in the centre concerning the safe administration and storage of medication and medicinal products. All medication was stored in a locked room in the centre. Residents were prescribed a number of as-required medications with this reaching 20 medications for some residents. Guidance was not present for staff on how and when to administer this medication including whether should there be, for example, two medicines which could treat pain or constipation. Guidance in the

administration of PRN medications also required review to ensure this reflected all aspects of a resident's life and recorded the rationale and effect of the administration of medication at all times.

Also, there was a large supply of medications present which were not routinely administered. For example, one resident had over 180 antihistamine tablets which had not been administered in more than three months. While an external audit had been scheduled for the day following the inspection the centre-specific audits had not identified these non-compliance or introduced actions to address these.

The residents in the centre were supported on the day of the inspection to participate in a number of activities completed within the centre by both staff members and external persons. External practitioners came into the centre setting, providing massage and reflexology services . It was not documented if the residents were happy for these activities to be completed within the centre or if they preferred to avail of services within the local community. From a review of the documentation, some residents received two of these services in a one-day period and also some received every week which incurred a cost for the resident. The provider had not reviewed the financial impact for the resident and also if this was in line with the residents choice and goals.From a review of the activities records, hairdressing and music sessions were facilitated in the centre. Should a resident wish to avail of an external activity this was dependent on the availability of a vehicle .

On arrival to the centre the inspectors were informed that no resident was currently at end of life. However, it was noted that four residents had a do not attempt resuscitation orders and advanced health care directives in place. From a review of documentation, the rationale for these was not clear, the consultation with the resident was not present and input from the relevant members of the multi-disciplinary team was not in place. This required review.

Since the previous inspection, it was evident that measures were in place to ensure the safety of residents in the centre. A safeguarding folder was in place which provided clear guidance for staff on actions should take should a concern arise including the reporting and recording of the same. The person in charge ensured to link with the relevant external agencies should a safeguarding concern arise to ensure plans in place were effective and regularly reviewed.

Regular resident meetings were completed with residents in the centre to provide residents with relevant information and to discuss issues about the centre. However, consultation with the residents in all areas of their daily lives was not evident. This included such areas as health care decisions, spending of own finances, and activities of their choice. Residents' access to an independent advocate was not consistently clear to ensure their opinions and choices were reflected in all decisions of their lives.

Regulation 13: General welfare and development

The registered provider had not ensured that each resident in the centre had access to opportunities for activation in accordance with their interests, capacity and development. Supports were not in place to evidence that residents' were supported to develop and maintain links with the wider community. On the day of inspection, it was noted that a number of external people came into the centre to deliver services and there was no evidence to demonstrate that the provider had offered the choice to support residents to receive or avail of these services in the community. The current issues with the vehicles in relation to accessibility and drivers did have an impact on the residents as a system was in place to take turns, which in effect restricted access to the community.

Judgment: Not compliant

Regulation 17: Premises

Since the previous inspection a review of the premises of the centre has been completed. Following a review of the use of a number of areas there is increased storage facilities in place. Practices within the centre were reviewed to ensure residents privacy and dignity was maintained when in their personal space.

The person in charge had introduced systems to ensure that all equipment and facilities within the centre were maintained in good working order and services as required.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

A review of practices relating to the storage and administration of medication was completed in the centre. Improvements were required to ensure that a safe supply of medications was present and guidance was available for staff on the safe administration of medications.

Judgment: Substantially compliant

Regulation 8: Protection

Since the previous inspection it was evident that measures were in place to ensure the safety of resident in the centre. This included staff training and organisational policy. The provider had measures to ensure that as required an investigation was completed while maintaining the well being of residents.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were not consulted in relation to supports and decisions. For example, one resident was paying for a physiotherapist on a weekly basis and there was no evidence that the provider had submitted a referral to the community services as outlined in their statement of purpose and contract of care for residents. Services such as hairdressing, chiropody, music, massage and reflexology was facilitated in house in the centre and their was no evidence how residents were consulted with around this activity and the financial impact. Some residents had to pay for staff supports to access activities in the community and there was no rationale as why they had to pay for this service, these charges were also not evident in the contract of care or statement of purpose.

The residents also had all their banking with one banking provider, this was the same for all the provider's registered centres. There was no evidence to support that residents were consulted in relation to their provider of choice.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glebe Lodge OSV-0001966

Inspection ID: MON-0041793

Date of inspection: 22/01/2024

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: There is a schedule of training in place to bring all staff up to date with mandatory training. 2 staff are outstanding on report writing, this has been delayed due to staff absence.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A full review of the safe administration of medication has been completed which addresses areas such as ordering and storage of medication. The pharmacist attended Glebe Lodge and completed an audit on 23/01/24 and all actions have been completed by 29/01/24. Actions included, review of monthly orders, return of overstock to the pharmacy. Nurses meeting with PIC scheduled for March 19th to discuss medication incidents and updates on Safe administration of medication Policy. The updated policy was rolled out to all staff to review on 01/03/24. A support plan has been put in place to support a resident needing a PRN medication while at home to allow family to provide personal care i.e haircut, nail cutting, shaving. The hand over sheet has been updated to ensure that there is a record of the rationale for administering the PRN medication while at home. On day of inspection 4 DNAR`s in place. Since then 1 review and discontinued on review. 1 reviewed and remains in place in consultation with resident, GP, Staff and Family, PIC is also meeting with family on 11/03/24. 1 resident with a DNAR is now deceased (DNAR had been reviewed prior to this) 1 DNAR is for a respite user, the DNAR is managed by the family in consultation with the day service. Currently there is 1 active DNAR in place. The policy on End of life is on the final stages of review. The price list of costings for residents has been updated, the PIC has spoken to all residents re same, and updated copy has been shared with Family. The Provider completed an audit on social funding for residents which they pay for. Glebe lodge uses this social funding, this is discussed with the resident, the application form is updated and will be reviewed again in 6 months. It addresses the residents will and preference,	

the rationale for the expenditure, how the decision was made and if it is connected to an identified goal or a direct request from the resident. The PIC will audit to ensure that the social funding requested has been used for the purpose it was applied and approved for.

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A new audit tool for safe administration of medication has been developed which will highlight issues in relation to medications when completed. The ADOS will complete another Provider Audit in April 2024. A full review of organizational audits will be completed as the provider is currently looking at alternative systems. A quality and Safety manager is currently being recruited who will be tasked to developing and completing audits that are fit for purpose. The PIC will discuss with staff re social funding and the new forms will be used going forward. The PIC will audit the social funding forms to ensure that they are competed properly and reflect the individual's choice and preference. The PIC reviewed all the charges and has process in place to ensure more than 1 therapy isn't booked for the same day.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Statement of purpose: The Statement of Purpose has been reviewed with all updates to reflect the current practice within the Centre. All costings and pricings are up to date.	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: The PIC has spoken to all the residents in relation to their activities provided by external practitioners to determine their will and preference, i.e massage, reflexology etc This is all documented in their personal files. The PIC has engaged with a local transport company to get costings for transport, this will support with meeting the needs of the residents in Glebe Lodge. The PIC has developed a visual activity planner to be completed.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Medicines and pharmaceutical services: The safe administration of Medication policy has been reviewed by the committee. PRN Protocols have been developed for all PRN medications. The storage and ordering of medication has been reviewed and updated to ensure safe storage and ordering of medication. The pharmacist attended Glebe Lodge	

and completed an audit on 23/01/24 and all actions have been completed by 29/01/24. Actions included, review of monthly orders, return of overstock to the pharmacy. Nurses meeting with PIC scheduled for March 19th to discuss medication incidents and updates on Safe administration of medication. The updated policy was rolled out to all staff to review on 01/03/24. A support plan has been put in place to support a resident needing a PRN medication while at home to allow family to provide personal care i.e haircut, nail cutting, shaving. The hand over sheet has been updated to ensure that there is a record of the rationale for administering the PRN medication while at home.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC has spoken to all the residents in relation to their activities provided by external practitioners to determine their will and preference, i.e massage, reflexology etc This is all documented in their personal files. The PIC has engaged with a local transport company to get costings for transport, this will support with meeting the needs of the residents in Glebe Lodge. The PIC has developed a visual activity planner to be completed. The resident that pays for his own physio has chosen to do same, the resident was previously referred to the community Physiotherapy, he was subsequently discharged, he requested additional physio, the organization paid for six sessions, the resident then choose to continue using the physiotherapist privately and pay for the service himself. The PIC spoke with the resident again about this cost, he continues to say he is content with the current arrangement. The price list of costings for residents has been updated in the SOP and Contract of support, the PIC has spoken to all residents re same, and updated copy has been shared with Family. The Provider completed an audit on social funding for residents which they pay for. Glebe lodge uses this social funding, this is discussed with the resident, the application for has been reviewed, and it identifies the residents will and preference, the rationale for the expenditure, how the decision was made and if it is connected to an identified goal or a direct request from the resident. The PIC will ensue that the social funding requested will be used for the purpose it was applied and approved for.
The PIC and Key workers will engage with the residents re their current banking arrangements and determine if they are satisfied with them, this will be noted in their personal records.
The provider will review the assessment of need to ensure that it includes choosing a bank account

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	04/04/2024
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	04/04/2024
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Not Compliant	Orange	04/04/2024

	their wishes.			
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	02/05/2024
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	02/05/2024
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	02/05/2024
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	02/05/2024
Regulation	The person in	Substantially	Yellow	02/05/2024

29(4)(a)	charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Compliant		
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	04/04/2024
Regulation 03(2)	The registered provider shall review and, where necessary, revise	Substantially Compliant	Yellow	07/03/2024

	the statement of purpose at intervals of not less than one year.			
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	04/04/2024
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	04/04/2024
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	04/04/2024

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.	Substantially Compliant	Yellow	04/04/2024