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:	Hansfield Group - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	11 July 2023
Centre ID:	OSV-0004040
Fieldwork ID:	MON-0038569

About the designated centre

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

The designated centre is located in North West Dublin and provides services though three units and an apartment adjacent to one of the units all of which are community based. Services are provided to persons with intellectual disabilities through 24 hour residential supports in the three units and supported living services in the apartment. The registered provider states that its central objective is to ensure that a safe, secure, supportive and caring environment is created which promotes the well-being of all residents. A person in charge and a team of social care workers and carers are employed in the centre to support residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Tuesday 11 July 2023	10:30hrs to 16:05hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

From what residents told us and what inspectors observed, it was evident that staff were endeavouring to support residents enjoy activities of their choice and to maintain relationships with people who were important to them. However, the inspector found poor levels of compliance across a number of regulations including protection, governance and management, records, complaints, individualised assessments and personal plans and staffing. These are outlined in the body of the report.

This designated centre is located in a suburb in West Dublin and consists of three houses. Two of those houses are individualised services, while the third house is home to four residents. The inspector had carried out two inspections in this centre in 2022 involving all three houses and therefore spent this inspection in the house where there was an identified risk. The house is a two-storey house in a housing estate. The house has a staff office and sleepover room downstairs, a toilet, a sitting room and a large kitchen and dining space. Upstairs there is a bathroom and four bedrooms, one of which has an en suite. The house was found to be in a good state of repair and nicely decorated. There were photographs of residents enjoying activities on the walls and each of their bedrooms was reflective of their interests and life stories.

On arrival to the centre, the inspector entered through the back door as both the front door and side door were locked. This was an approved restrictive practice for a specific purpose and had been notified to the Office of the Chief Inspector. One resident was standing at the front door for a long period of time indicating that they wanted to go out. However, it was not possible for staff to accommodate their request due to an unfamiliar relief staff being on duty. The resident intermittently stood at the door for the following two hours and was brought out when a regular staff member returned. The inspector had the opportunity to meet with all of the residents over the course of the day. One of the residents told the inspector that they wished to live on their own and that they did not want to live in the house with the other residents. The other residents had higher communication support needs and the inspector observed these residents going about their afternoon routines. Interactions between staff members on duty and residents were noted to be respectful and kind.

Residents in the house had a range of communication support needs. Some residents used Lámh sign, gesture and pointing while others used some words and body language. Another resident used speech to communicate. It was evident that residents' rights to communicate using a method of their choice were promoted. The house had visual supports on the wall in relation to routines and staff on duty. Residents had communication passports in place and they had input from Speech and Language Therapy where it was required. There was easy-to-read information available to support residents' to understand information about different areas such as safeguarding, rights and various aspects of infection prevention and control

(IPC). One of the residents had recently commenced a trial of using Talking Mats to enhance their interaction with staff. Interactions between staff and residents were found to be respectful and kind.

Residents in the house attended day services between three and four days per week. They had access to transport in the house and did a range of activities such as going out for lunch, going for walks engaging in Special Olympics, baking, golf and shopping. Residents were supported to engage in household chores and to be involved in planning and preparation of meals, where they wished. Weekly meetings took place with residents which encompassed discussions about the week ahead, infection prevention and control measures and meal planning.

The inspector reviewed input from family and residents to the annual review carried out in 2021. While some of the residents gave positive feedback, another stated that they did not wish to live in the centre. The inspector noted that there had been three complaints relating to this house in the past two months. One of these was from a resident who expressed frustration at the lack of progress in relation to their assessment and proposed move. Documentation viewed reported that the resident "did not feel listened to". The resident had consistently requested a change in accommodation for a number of years, a move which was supported by members of a multidisciplinary team involved in their care. This is discussed further under Regulation 34: Complaints.

Due to incompatibility of residents living in the house, a number of peer-to-peer incidents had taken place in the year prior to this inspection taking place. Staff described the impact of these incidents upon residents and the upset caused. A family member was documented as being upset at the ongoing nature of these incidents affecting their relative. Staff spoke about some of the difficulties in trying to manage these situations as they arose. Documentation viewed indicated that it was noted by staff that residents were much more communicative and interactive when the person causing concern was not in the house. Staff noted that they were spending more time in communal areas such as the sitting room and engaging in more household chores. Safeguarding incidents referred to "considerable disruption in the atmosphere" in the house.

Overall, the inspection had poor findings with improvements required in the areas of staffing, safeguarding, governance and management, records and individual assessment and personal plans. The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk-based inspection which took place following an ongoing trend of peer-to-peer safeguarding incidents in the centre. A Provider

Assurance Report was sought and submitted to the Office of the Chief Inspector in January 2023 due to ongoing peer-to-peer incidents in the centre. This report gave assurances on a number of measures which the provider was taking to safeguard residents. One of these assurances included seeking alternative accommodation for one resident. This action had also been committed to in the provider's compliance plan for the inspection which had taken place in October 2022. An update to this compliance plan was sought by the inspector in June 2023. This did not give suitable assurances on progress of this action in line with the time lines provided. Minutes of two admissions, discharge and transfer meetings held in November 2022 and May 2023 were viewed. While the resident was recorded on the minutes as being on a transfer list, the minutes did not give further detail on discussions which took place and did not identify any actions relating to this resident. Due to continued inaction from the provider in putting effective safeguarding measures in place and progressing actions in line with time lines given to the Office of the Chief Inspector, the inspector issued an immediate action to the provider seeking assurances on Regulation 8: Protection. Suitable assurances were provided following the inspection.

The annual review for 2022 was in progress on the day of the inspection. The inspector viewed the annual review for 2021 and found that it met regulatory requirements. The person in charge had analysed resident responses and put actions into place where they were required. Where actions were required by the provider, there was evidence of the person in charge highlighting areas of need to management. Six-monthly unannounced provider visits had taken place in line with regulatory requirements. However, while these had identified some areas requiring improvement, actions in high-risk areas were not identified. For example, the most recent six-monthly unannounced visit in May and June 2023 referred to safeguarding incidents and identified that a resident had indicated their wish to live alone. However, actions in relation to this were not identified. Individualised assessments and personal plans referred to care plan audits, but did not reflect the findings of assessments relating to an individual to indicate that the designated centre was unsuitable for that resident. Staffing and risk management were also reviewed but did not self- identify issues found on this inspection.

At centre level, the person in charge had a schedule of audits in place which were identifying areas requiring improvement and progressing these actions in a timely manner. They kept a central action log to ensure monitoring and oversight of actions from provider visits and internal audits. The person in charge was absent on the day of the inspection, but it was evident that they had systems in place to ensure they had good oversight of the centre at a local level. They met with their manager regularly and it was evident throughout documentation that the person in charge was advocating on behalf of all residents on the need for additional measures to be put in place. Staff meetings took place regularly and were resident-focused in nature.

Evidence reviewed by the inspector in relation to staffing levels found that this part of the designated centre did not have adequate numbers of staff in place to ensure that control measures identified to manage risks in the centre were consistently implemented and to enable residents to take part in activities of their choosing. The

staffing ratio was documented as being inadequate due to changing needs of one resident. There had been a high number of agency staff used in the house in the two months prior to the inspection taking place which interrupted residents' continuity of care.

Staff training and development had improved since the last inspection. All of the team had completed mandatory training in areas such as safeguarding, fire and manual handling in addition to a number of modules relating to infection prevention and control and applying a human-rights based approach to health and social care. There was a schedule in place for supervision with staff and staff reported that they were well supported in their role.

While it is acknowledged that the person in charge was on leave on the day of the inspection, the inspector was unable to locate or access some records, which were required for the inspection in line with Schedule 3 and 4 of the regulations. For example, an individual needs and preference assessment was not available on the day in the centre. This was furnished to the inspector two weeks after the inspection taking place. Incidents and accidents which had occurred between January and May of 2023 were not accessible in the centre. Other records such as the complaints log, the risk register and six-monthly unannounced visits were emailed to the inspector by the person participating in management on the day of the inspection and the day following the inspection.

The inspector viewed the complaints log for the centre. The person in charge had clearly documented these complaints in addition to any required actions. A central complaints log was kept to maintain oversight. One of the residents had made a complaint in relation to progressing their assessment to source more suitable accommodation. A record of a meeting held with the resident noted that the complaint was to be closed. However, the issue at hand remained and it was unclear whether or not the complainant was satisfied with the outcome of this meeting.

Regulation 15: Staffing

The inspector found that there were not adequate staff numbers in the house inspected to meet residents' assessed needs and to ensure control measures for identified risks were consistently implemented. The staff ratio to residents was documented as having a negative impact for residents. For example, one resident required one-to-one staffing for large portions of the day to meet their assessed needs. This meant that other residents were not being facilitated to do activities of their choosing in addition to ensuring that safeguarding measures could be consistently implemented.

There was one vacancy on the day of the inspection. A review of rosters indicated that there had been a total of 17 relief or agency staff used to cover 23 shifts over the month of May which disrupted residents' continuity of care. This was evident on the day of the inspection with a resident being unable to leave the house for the

morning due to unfamiliar staff being on duty.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had completed mandatory training in a number of areas including fire precautions, protection and manual handling. Since the last inspection, all staff members had completed training in managing behaviours of concern and autism. Staff had completed a number of modules related to infection prevention and control. A small number of staff were due refresher training in food safety and they were enrolled on these courses. Staff supervision took place in line with the provider's policy and there was a clear schedule in place for these sessions.

Judgment: Compliant

Regulation 21: Records

Records required for the inspection were not all accessible in the designated centre in line with regulatory requirements. These included the complaints log, staff training records, six-monthly unannounced provider visits. While most of this information was provided to the inspector by email on the day of the inspection, one piece of information requested was not furnished to the inspector until two weeks after the inspection took place.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector found that the governance and management arrangements in place were ineffective in ensuring that risks were appropriately responded to and that actions were progressed in a timely manner. Six-monthly unannounced visits were taking place, but these were not identifying or therefore progressing actions which were posing a risk to residents.

The provider had committed to ensuring an alternative placement was found for a resident by June 2023. This had been identified as a need in 2021 and there was documentation from various multidisciplinary meetings indicating and supporting the need for this move. In spite of ongoing safeguarding incidents in the centre, the actions committed to in the provider's compliance plan were not progressed. Due to

the high level of concern posed to residents, the inspector issued the provider with an immediate action on Regulation 8: protection. Suitable assurances were following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

There had been three complaints for this part of the centre in the two months prior to the inspection. One resident had made a complaint in relation to slow progress on their individual needs and preferences assessment. The complaint referenced not being listened to and not receiving feedback in a way they could understand relating to their complaint. A meeting took place between the resident and management. This documented that the complaint was closed due to the individual being aware that the provider was progressing their move. However, it was unclear whether or not the complainant was satisfied with that outcome.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that staff were endeavouring to provide a service which was person-centred and that saw them enjoy activities of their choosing. It was evident that residents' meetings were held and every effort to provide residents with information about various aspects of the service was made by the person in charge and the staff. A review of the residents' care plan indicated that upon assessment, the resident was not suited to their current accommodation due to safeguarding and mobility issues. The person in charge had documented this a number of times, with the support of members of the multidisciplinary team since 2021. The centre was therefore not suitable to meet this resident's assessed needs in line with their expressed will and preference.

As referred to in other parts of the report, safeguarding in the centre was of concern. There had been 20 notifications submitted to the Office of the Chief Inspector in the 12 months prior to this inspection taking place. These were peer-to-peer incidents. The inspector found the provider and the person in charge had put safeguarding measures in locally which included speaking with residents about safeguarding and speaking with staff at team meetings about safeguarding concerns and their management. A folder had been set up in the centre in order to collate progress and put in place group and individual supports. A social worker had also met with all residents. However, the inspector found that incidents continued to occur. These incidents were having an ongoing negative impact on residents, as

reflected in the beginning of the report.

There were systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. The person in charge had a risk register in place and had implemented risk assessments for both the centre and individuals in the centre in line with their assessed needs. Adverse incidents were documented and trended and learning was shared with the staff team. There was evidence that they had liaised with members of the multidisciplinary team in order to ensure that identified risks were appropriately documented and submitted to management where required. However, some of the risk assessments required review to ensure they were reflective of the current risks in the centre.

The inspector found that the house was suitably equipped with detection and containment systems, fire fighting equipment and emergency lighting. These were regularly checked and maintained. Improvements had been made in the documentation of drills since the last inspection. However, some of the residents presented with mobility issues meaning that they would be slower on the stairs. No drill had been carried out involving all residents being upstairs to ensure that safe and timely evacuation was possible in this scenario. In addition, a review of residents' personal emergency evacuation plans was required to ensure that they gave clear guidance to staff on how to manage the group of residents in the event of a fire.

Regulation 26: Risk management procedures

Risk assessments in the centre required review to ensure that they were reflective of the current risks and to ensure that ratings in the centres' risk register and the residents' risk assessments correlated. For example, for a risk assessment for managing behaviours of concern, this was rated as low. The resident's risk assessment was rated as high risk in addition to a number of incidents of behaviour of concern occurring. For another resident, they were noted to be slow on descending the stairs. However, this was rated as low risk without evidence that they could evacuate from upstairs in a timely manner.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire drills required improvement in the centre to ensure that the safe and timely evacuation of all residents was achievable with the minimum staffing complement.

Three of four residents were documented as having the potential to be slower than others while descending the stairs. However, a review of the previous six drills noted

that there was no drill carried out while all of the residents were upstairs. Residents had personal emergency evacuation plans in place. However, these needed review to ensure that staff were given clear guidance on the actions required to safely evacuate the group. For example, three of four residents' plans documented that they were required to go last in the group to ensure that they did not impede the way of their house mates. Given the number of agency staff that were required, this posed a risk to residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector found that the designated centre was assessed by the multidisciplinary team in liaison with the person in charge and staff as being unsuitable to meet the assessed needs of one resident. The resident had changing mobility needs and behaviour support needs. They had expressed their desire to move to an accessible property and to live alone for over a year.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that residents in the house were negatively impacted in their home due to ongoing safeguarding incidents. While a number of measures were put in place, actions committed to ensure safety of all residents had not been progressed by the provider. Incidents were continuing to occur and documented as having a negative impact on the quality of life of residents in the house.

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	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Hansfield Group - Community Residential Service OSV-0004040

Inspection ID: MON-0038569

Date of inspection: 11/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing ratio of 2:4 increased to 3:4 on 12th July for identified high risk times daily. This will be reviewed to determine its effectiveness in managing safeguarding concerns. At times of sick leave and annual leave the provider will seek to assign regular relief and agency staff.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All information requested has been provided to the inspector.	
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 secured an alternative placement for one resident who will be supported to move there by 15/09/23. The annual review which had been completed on 6th July is available in the centre and identified areas for improvement; an action plan has been developed to address these.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The provider will deal with complaints as per service policy and documentation as evidenced in residents files will stipulate whether the residents were satisfied with outcome.	
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 the risk register and risk assessment	

documentation accurately reflects all identified risks in the centre.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A simulated night time fire drill has been completed and all residents evacuated in a timely manner. The fire plan for the centre has been reviewed and updated to ensure clear plans are in place for the safe evacuation of all residents.	
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 needs and preferences of the resident in question have been progressed and funding is currently being sought to meet these needs. An alternative placement has been sourced for this resident in the interim due to safeguarding concerns, this will also meet some of his identified preferences. This resident will transfer with the support of a well developed transition plan by 15/09/23.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Current staffing ratio of 2:4 has increased to 3:4 from 12th July for identified high risk times daily. This will be reviewed to determine its effectiveness in managing safeguarding concerns. All resident's safeguarding plans and risk assessments have been reviewed and updated. Safeguarding concerns will continue to be managed in line with the organisation's Safeguarding policy. One resident will be facilitated to move with a full transition plan by 15/09/23.	

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	12/07/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	12/07/2023
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as	Not Compliant	Orange	18/07/2023

	specified in Schedule 3 are maintained and are available for inspection by the chief inspector.			
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	12/07/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	12/07/2023
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	12/07/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	31/08/2023

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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.	Substantially Compliant	Yellow	27/07/2023
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	27/07/2023
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.	Not Compliant	Orange	27/07/2023
Regulation 05(3)	The person in charge shall	Not Compliant	Red	15/09/2023

	ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	12/07/2023